Calendar No. 484

105TH CONGRESS, *2d Session* | SENATE | REPORT 105–257

FEDERAL EMPLOYEES HEALTH CARE PROTECTION ACT OF 1997

R E P O R T

OF THE

COMMITTEE ON GOVERNMENTAL AFFAIRS UNITED STATES SENATE

Together with

ADDITIONAL VIEWS

TO ACCOMPANY

H.R. 1836

TO AMEND CHAPTER 89 OF TITLE 5, UNITED STATES CODE, TO IMPROVE ADMINISTRATION OF SANCTIONS AGAINST UNFIT HEALTH CARE PROVIDERS UNDER THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM, AND FOR OTHER PURPOSES

JULY 21 1998.—Ordered to be printed

U.S. GOVERNMENT PRINTING OFFICE

59–010 WASHINGTON : 1998

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105TH CONGRESS *2d Session* | SENATE | REPORT 105–257

THE FEDERAL EMPLOYEES HEALTH CARE PROTECTION ACT OF 1998

JULY 21, 1998.—Ordered to be printed

Mr. THOMPSON, from the Committee on Governmental Affairs, submitted the following

REPORT

[To accompany H.R. 1836]

The Committee on Governmental Affairs, to which was referred the bill (H.R. 1836) to strength the integrity and standards of the Federal Employee Health Benefits Program (FEHBP) and allow it to maintain its reputation as a high quality and cost-effective program, and for other purposes, having considered the same, reports favorably thereon with an amendment and recommends, by a vote of 9–0, that the bill as amended do pass.

CONTENTS

I. SUMMARY AND PURPOSE

H.R. 1836, the Federal Employee Health Care Protection Act of 1998, was designed to make a number of improvements to the Federal Employee Health Benefits Program (FEHBP). Specifically, the bill would allow the government to impose sanctions on the providers or bar them from selling coverage to any government agency; would encourage full disclosure in discounted rate agreements; and would establish standards for readmitting discontinued health

plans and for crediting of associated contingency reserves. Additionally, the bill would make a number of technical changes.

II. Legislative History

H.R. 1836 was introduced by Representative Dan Burton (R–IN) on June 10, 1997. The bill was referred to the House Government Reform and Oversight Committee on June 10, 1997 and to the Subcommittee on Civil Service on June 11, 1997. The legislation was marked up, with amendments, by the Subcommittee on October 22, 1997, and by the full Committee on October 31, 1997. No hearings were held, nor written testimony received. The House passed H.R. 1836 by voice vote, under suspension of the rules, on November 4, 1997.

On November 5, 1997, H.R. 1836 was referred to the Senate Committee on Governmental Affairs, and to the Subcommittee on International Security, Proliferation, and Federal Services on November 11, 1997. On March 31, 1998, a majority (8) of the Subcommittee Members approved reporting favorably H.R. 1836 to the full Committee. No hearings were held, nor testimony received.

The Committee proceeded to consider H.R. 1836 on April 1, 1998. A technical amendment to section 4 was offered by Senator Cochran. The amendment changed certain dates in Section 4 of the bill to recognize that the health plans currently offered to employees by the Federal Reserve and the Federal Deposit Insurance Corporation did not cease to exist in January 1998. Those agencies may now terminate those health plans before January 3, 1999, thereby allowing employees of those agencies to enroll in the Federal Employee Health Benefits Program. The amendment was adopted by voice vote. H.R. 1836, as amended, was considered en bloc with other legislation and was reported favorably to the full Senate by a recorded vote of 9–0. Voting in the affirmative were Senators Akaka, Cleland, Durbin, Glenn, Levin, Cochran, Nickles, Roth, and Thompson.

III. Need for Legislation

H.R. 1836, as amended by the Committee, addresses several areas of operation of the Federal Employees Health Benefits Program. The legislation provides the Office of Personnel Management with additional ways of fighting waste, fraud, and abuse in the program. Thus, OPM will be equipped to deal effectively with health care providers who participate in fraudulent activities affecting the FEHBP. In addition, the legislation permits certain employees of the Federal Deposit Insurance Corporation and the Federal Reserve Board to participate in the FEHBP, establishes statutory requirements regarding the readmitting of health care plans sponsored by employee organizations that have previously discontinued participation in the FEHBP, and increases the maximum amount of the physicians' comparability allowance from $20,000 to $30,000. These changes improve the operation of the program to the benefit of program enrollees, carriers, taxpayers and the federal government.

One area of program operation addressed by H.R. 1836 involves the practice of plan carriers contracting with third parties to obtain

discounts from health care providers. The Committee recognizes the important role that Preferred Provider Organizations (PPOs) play in today's health care market. Frequently, the PPOs negotiate discounted rate schedules with health care providers in exchange for certain incentives. The incentives may include an agreement to steer patients to the provider, in the case of so-called "directed PPOs," or they may include financial incentives such as prepayment or prompt payment in the case of so-called "non-directed PPOs." Both directed and non-directed PPOs provide legitimate and valuable benefits to health care providers, carriers, and patients.

Based upon concerns raised to the House Government Reform and Oversight Committee by the American Medical Association and the American Hospital Association that certain payers were taking advantage of discounts to which they were not entitled, the Office of Personnel Management Inspector General was requested to conduct a review ". . . to determine whether silent PPOs were used by FEHBP carriers to capture discounts to which they were not entitled." That report is included in the Additional Views submitted by Senator Thad Cochran, Chairman of the Subcommittee on International Security, Proliferation and Federal Services.

Under this bill, OPM must encourage carriers to seek assurances from any person with whom they contract to obtain discounted rates from providers that the conditions for such discounts are fully disclosed to the providers who grant them. Further, the Committee recognizes the necessity of the existence of contracts between providers and networks, and the benefits that PPO arrangements provide the FEHBP.

IV. Section-by-Section Analysis

SECTION 1. SHORT TITLE

This Act may be cited as the "Federal Employees Health Care Protection Act of 1998".

SECTION 2. DEBARMENT AND OTHER SANCTIONS

Section 2 relates to debarment and other sanctions on health care providers in the Federal Employees Health Benefits Program (FEHBP).

Definitions

Current law.—Defines the terms "provider of health care," "individual covered under this chapter," and "convicted."

H.R. 1836.—Retains these definitions and adds another for "should know,"—"a person, with respect to information, acts in deliberate ignorance of, or in reckless disregard of, the truth or falsity of the information, and no proof of specific intent to defraud is required."

Authority to debar

Current law.—The Office of Personnel Management (OPM) has permissive authority to debar, i.e., exclude certain providers of health care services or supplies from participating in the FEHBP.

H.R. 1836.—Retains permissive authority to debar, but adds mandatory authority to debar.

Grounds for debarment

Current law.—OPM may debar any provider that has been convicted, under federal or state law, or a criminal offense—

(1) relating to fraud, corruption, breach of fiduciary responsibility or other financial misconduct in connection with the delivery of a health care service or supply;

(2) relating to neglect or abuse of patients in connection with the delivery of a health care service or supply;

(3) in connection with the interference with or obstruction of an investigation or prosecution of a criminal offense described in (1) or (2); or

(4) relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

OPM also may debar any provider—

(1) whose license to provide health care services or supplies has been revoked, suspended, restricted, or not renewed by a state licensing authority for reasons relating to the provider's professional competence or performance or financial integrity; or

(2) that surrendered such a license while a formal disciplinary proceeding was pending before such an authority, if the proceeding concerned competence, performance, or financial integrity.

H.R. 1836.—Changes permissive debarment to mandatory for any provider convicted of criminal matters cited in grounds 1–4 above.

Further, this provision adds an additional ground for mandatory debarment for any provider that currently is suspended or excluded from participation under any program of the federal government involving procurement or nonprocurement activities.

The section retains the permissive debarment for the above grounds relating to professional licensing.

The section adds four additional grounds for permissive debarment for—

(1) any provider that is an entity directly or indirectly owned, or with a five percent or more controlling interest, by an individual who was convicted of any offense that is a ground for mandatory debarment, against whom a civil monetary penalty has been assessed, or who has been debarred from participating in FEHBP;

(2) any individual who directly or indirectly owns or has a controlling interest in an entity and who knows or should know of the action constituting the basis for the entity's conviction of any offense for which mandatory debarment may be imposed, assessment with a civil penalty, or debarment from participation;

(3) any provider that OPM determines, in connection with claims presented, has charged for health care services or supplies in an amount substantially in excess of the provider's customary charges for such services or supplies (unless OPM finds there is good cause for such a charge) or has charged for health

care services or supplies substantially in excess of the needs of the covered individual or which are of a quality which fails to meet professionally recognized standards for the services or supplies; or

(4) any provider that OPM determines has committed acts for which a civil penalty may be imposed.

Consequence of debarment

Current law.—No payment may be made by a carrier pursuant to any FEHBP contract to a provider that is barred from participating in the program for any service or supply furnished by the provider during the period of debarment.

H.R. 1836.—No change.

Authority for civil penalties and additional sanctions

Current law.—OPM has permissive authority to impose, in addition to other penalties that may be prescribed by law, and after consulting with the Attorney General, a civil monetary penalty of not more than $10,000 for any item or service involved.

In addition, a provider against whom a civil penalty has been imposed is subject to a mandatory assessment of not more than twice the amount claimed for each item or service.

Moreover, OPM has permissive authority in the same proceeding to bar such provider from participating in FEHBP.

H.R. 1836.—No change.

Grounds for imposing civil penalties and additional sanctions

Current law.—OPM has permissive authority to impose a monetary civil penalty, mandatory authority to impose an assessment, and permissive authority to debar whenever it determines—

(1) in connection with a claim presented under FEHBP, that a provider of health care services or supplies has charged for health care services or supplies—

(A) that the provider knows or should have known were not provided as claimed; or

(B) in an amount substantially in excess of the provider's customary charges or substantially in excess of the needs of the covered individual or are of a quality that fails to meet professionally recognized standards for such services or supplies;

(2) has knowingly made, or caused to be made, any false statement of a material fact which is reflected in an FEHBP claim; or

(3) has knowingly failed to provide any information to a carrier or to OPM to determine whether a payment or reimbursement is payable under FEHBP or the amount of any such payment or reimbursement.

H.R. 1836.—Amends paragraph (1) above by substituting "claims" in place of "claim," retaining (A), deleting (B), and replacing it with two grounds for any provider that has charged for a health care service or supply which the provider knows or should have known involves—

(B) charges in violation of applicable charge limitations under 5 U.S.C. section 8904(b) relating to Medicare; or

(C) an item or service furnished during a period when the provider was excluded from participation in FEHBP pursuant to a determination by OPM, other than as permitted under subsection (g)(2)(B) relating to postponing the effective date of a debarment.

Time limitation on debarment or imposing civil penalties

Current law.—OPM may not initiate any debarment proceeding based on a criminal conviction later than six years after a provider was convicted and may not impose a civil penalty, assessment, or debarment later than six years after the date a claim meriting a civil penalty is presented.

H.R. 1836.—No change.

Factors to be considered in debarment or imposing civil penalties

Current law.—In determining the appropriateness of imposing debarment, a period of debarment, or a civil penalty, OPM is required to take into account—

(1) the nature of any claims involved and the circumstances under which they were presented;

(2) the degree of culpability, history of prior offenses or improper conduct of the provider involved; and

(3) such other matters as justice may require.

H.R. 1836.—Limits consideration of these factors only to cases where debarment is permissive or to civil penalties; it does not require considering them for mandatory debarments.

Effective date of debarment

Current law.—Debarment of a provider under permissive debarment authority or in connection with a civil penalty is effective at such time and upon such reasonable notice to the provider and to carriers and covered individuals as specified by OPM regulations. Debarment is effective for any health care services or supplies furnished by a provider on or after the effective date of debarment, except for inpatient services to an individual who was admitted to the institution before the date of debarment until 30 days after that date, unless OPM determines a shorter period is necessary in order to protect the health or safety of the individual receiving those services.

Any notice of debarment must specify the date the debarment will become effective and the minimum period it will remain in effect.

H.R. 1836.—In most circumstances, under mandatory and permissive debarment authorities, the debarring official has authority to determine the effective date of debarment without regard to a hearing. Any provider may request a hearing after the effective date of debarment. However, in the case of permissive debarments on the grounds that would subject the provider to civil monetary penalties, OPM cannot make a determination which is adverse to a provider until the provider has been given reasonable notice and an opportunity for the determination to be made after a hearing. The hearing must occur *before* the adverse action is taken, unless OPM determines that the health or safety of individuals receiving health care warrants an earlier date.

Period of debarment

Current law.—Generally, the minimum period as specified by OPM regulation. Existing law does not mandate a minimum period of debarment.

H.R. 1836.—Generally imposes that providers convicted under federal or state law of specified offenses must be debarred for at least three years. Those offenses include:

(1) fraud, corruption, breach of fiduciary responsibility or other financial misconduct;

(2) neglect or abuse of patients;

(3) interference with or obstruction of an investigation or prosecution of a criminal offense described in paragraphs (1) and (2) above;

(4) a criminal offense relating to the manufacture, distribution, prescription, or dispensing of a controlled substance.

Termination of debarment

Current law.—A provider permissively barred from participating in the FEHBP may, *after* the expiration of the minimum period of debarment specified in the notice, apply to OPM for termination of debarment. OPM may terminate the debarment after the end of the minimum debarment period if it determines that there is no basis under the permissive debarment authority or the civil penalty authority for continuing the debarment and there are reasonable assurances that the types of action which formed the basis for the original debarment have not recurred or will not recur.

OPM may terminate the debarment of a provider before the expiration of the minimum debarment period if it determines that there is no basis for continuing the debarment, there are reasonable assurances that such behavior has not and will not recur, and early termination is warranted because the provider is the sole community provider or the sole source of essential specialized services in a community.

H.R. 1836.—Authorizes OPM to terminate a mandatory debarment *after* the minimum debarment period if it determines that there is a no basis under mandatory debarment authority for continuing the debarment.

Notice and hearing requirements and judicial review

Current law.—OPM may not make a determination under permissive debarment authority or civil penalty authority adverse to a provider until *after* the provider has been given written notice and an opportunity for a hearing, *i.e., a pre-adverse action hearing.* Any person adversely affected by an OPM final adverse decision may obtain review of the decision in the United States Court of Appeals for the Federal Circuit. A written petition requesting modification or setting aside of OPM's decision must be filed within 60 days after the provider is notified.

H.R. 1836.—Amends this provision by substituting that any provider that is subject of an adverse OPM determination is entitled to reasonable notice and an opportunity to request a hearing of record, i.e. a post-adverse action hearing of record. OPM is required to grant a request for a hearing upon a showing that due process

rights previously have not been afforded for any finding of fact relied upon as a cause for an adverse determination.

Such a hearing is conducted without regard to subchapter II of chapter 5 of title 5, United States Code, relating to administrative procedure, and chapter 7 of title 5, relating to judicial review. The hearing is conducted by a hearing officer who is appointed by the Director of OPM. A request for a hearing is required to be filed within such a period and in accordance with procedures as prescribed by OPM.

Any provider adversely affected by a final decision made after a hearing may seek review in the United States District Court for the District of Columbia or for the district in which the plaintiff resides or has his principle place of business by filing an appeal within 60 days from the date the decision is issued.

The court has power to enter, upon the pleadings and record, a judgment affirming, modifying, or setting aside, in whole or in part, OPM's decision, with or without remanding the cause for a hearing. The district court may not set aside or remand an OPM decision unless there is not substantial evidence on the record to support the findings of OPM or unless the action taken by OPM constitutes an abuse of discretion.

Venue of civil penalty actions

Current law.—A civil action to recover civil monetary penalties or assessments must be brought by the Attorney General and may be brought in the district court where the claim involved was presented or where the person subject to the penalty resides. Amounts recovered are paid to OPM for deposit into the Employees Health Benefits Fund.

H.R. 1836.—Retains current law and adds that the amount of a penalty or assessment as determined by OPM, or other amount OPM may agree to in compromise, may be withheld from any sum then or later owing by the United States to the party against whom the penalty or assessment has been levied.

Effective dates

Current law.—Not applicable.

H.R. 1836.–With three exceptions, the amendments made by H.R. 1836 take effect on the date of enactment.

The first exception relates to permissive debarment under specified circumstances and applies only to the extent that the misconduct which is the basis for the permissive debarment occurs after the date of enactment.

The second exception involves civil monetary penalties and assessments for violations of charge limitation relating to Medicare and applies only for charges for items or services furnished after the date of enactment.

The third exception relates to the minimum three year period of mandatory debarment for grounds prescribed in the mandatory debarment section and applies only with respect to criminal convictions that occur after enactment.

SECTION 3. MISCELLANEOUS AMENDMENTS RELATING TO THE HEALTH BENEFITS PROGRAM FOR FEDERAL EMPLOYEES

Current Law.—Does not specify that an association of organizations may serve as the carrier for any health benefits plan in the FEHBP. It also does not specify that the carrier for the government-wide Service Benefit Plan need not contract with underwriting affiliates licensed in all of the States and the District of Columbia.

H.R. 1836.—Amends the definition of "carrier" and the description of the govenrment-wide Service Benefit Plan under current law. Additionally, H.R. 1836 broadens the preemption provisions in current law to enable national plans to offer uniform benefits and rates to enrollees regardless of where they live.

Specifically, section 3 does the following:

Amends paragraph (7) of section 8901, title 5, U.S.C. by striking "organization" and inserting "organization and an association of organizations or other entities described in this paragraph sponsoring a health benefits plan."

Amends paragraph (1) of section 8903, title 5, U.S.C. by striking "plan" and inserting "plan, which may be underwritten by participating affiliates licensed in any number of States."

Amends section 8902(m) of title 5, U.S.C. by striking "(m)(1) and all that follows through that paragraph, and inserting "(m)(1) The terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plan."

SECTION 4. CONSISTENT COVERAGE FOR INDIVIDUALS ENROLLED IN A HEALTH PLAN ADMINISTERED BY THE FEDERAL BANKING AGENCIES

Current law.—Requies that federal retirees must have participated in the FEHBP for at least five years immediately preceding retirement in order to be eligible to participate in the FEHBP as a retiree and for certain continuation of coverage upon separation from service. In recent years, the Federal Reserve Board, the Federal Deposit Insurance Corporation, the Office of the Comptroller of the Currency, and the Office of Thrift Supervision have sponsored their own health insurance plans for their employees. These agencies are now dropping those plans and participating in the FEHBP. P.L. 103–409 allowed employees of the Office of the Comptroller of the Currency and the Office of Thrift Supervision to participate in the FEHBP if they had been enrolled in their agency's plan before separation in order to meet the five year requirement.

H.R. 1836.—Would deem participation in a health insurance plan sponsored by the Federal Deposit Insurance Corporation and the Board of Governors of the Federal Reserve System to meet the enrollment requirements for participation in the FEHBP as retirees or under continuation of coverage conditions. it would require these federal banking agencies to make a payment to the FEHBP fund to cover the government's share of premium costs for retirees who would, by the Act, be made eligible for FEHBP coverage as an annuitant.

In an amendment adopted by the Committee, the effective dates for the transition in the FEHBP is changed from "on January 3, 1998" to "on or before January 2, 1999" to ensure that the transition in the FEHBP is limited only to those Federal Reserve and FDIC employees who were participating in the health care plans that those agencies are now terminating. In addition, this amendment reflects the fact that the health plans currently offered to employees by the Federal Reserve and the FDIC did not cease to exist in January 1998; and that those agencies may now terminate those health plans anytime before January 3, 1999 thereby allowing employees to move into the FEHBP.

SECTION 5. FULL DISCLOSURE IN HEALTH PLAN CONTRACTS

Current law.—Does not have a full disclosure requirement.

H.R. 1836.—Directs OPM to encourage carriers who obtain provider discounts to seek assurance that the conditions for such discounts are fully disclosed to the providers who grant them.

SECTION 6. PROVISIONS RELATING TO CERTAIN PLANS THAT HAVE DISCONTINUED THEIR PARTICIPATION IN FEHBP

Current Law.—Does not allow health care plans sponsored by an employee organization to reenter the FEHBP after previously discontinuing its participation. Additionally—with respect to the contingency reserves of the discontinued plans—OPM is required to distribute those reserves to plans continuing in the FEHBP in the contract year after the discontinuance.

H.R. 1836.—Amends chapter 89 of title 5 by adding the following after section 8903(a): 8903(b). Authority to readmit an employee organization plan.

In the event that a plan described by section 8903(3) or 8903a is discontinued (other than in the circumstance described in section 8909(d)), the plan may be reconsidered for FEHBP eligibility for any contract year after the third contract year in which the plan was discontinued.

Subsection (e) of section 8909 of title 5, U.S.C., is amended by striking "(e) and inserting "(e)(1)" and by adding language that requires OPM to distribute the contingency fund reserves of certain discontinued plans within 2 contract years.

SECTION 7. MAXIMUM PHYSICIANS COMPARABILITY ALLOWANCE PAYABLE

Current Law.—In 1978 the Federal Physicians Comparability Act, PL 95–603, was passed and provided a maximum of $10,000 per year in additional compensation for one year of service for physicians where significant recruitment and retention problems exist. In 1987 the maximum physicians comparability allowance (PCA) as increased by Congress to $20,000 per year. These provisions are codified in 5 U.S.C. 5948 and implementing regulations were issued by OPM in 5 C.F.R. 595.

H.R. 1836.—Increases the maximum physicians comparability allowance Federal agencies may pay from $20,000 to $30,000 per year.

SECTION 8. CLARIFICATION RELATING TO SECTION 8902(k)

Current Law.—Requires carriers offering health benefit plans under the FEHBP to provide for direct payment for services which may be performed by a clinical psychologist, optometrist, nurse midwife, nursing school administered clinic, or nurse practitioner/clinical specialist, licensed or certified as such under Federal or State law, as applicable, or by a qualified clinical social worker as defined in section 8901(11).

H.R. 1836.—Amends section 8902(k) of title 5, U.S.C., by inserting after paragraph (1) language ensuring that no health benefits plan is precluded from providing direct access or direct payments for services provided by a health care professional not listed in paragraph (1), as long as the professional is licensed or certified as such under Federal or State law.

V. ESTIMATED COST OF LEGISLATION

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, June 1, 1998.

Hon. FRED D. THOMPSON,
Chairman, Committee on Governmental Affairs, U.S. Senate, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for H.R. 1836, the Federal Employees Health Care Protection Act of 1998.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contacts for the federal budgetary impact are Tom Bradley (for the Federal Employees Health Benefits program), Mary Maginniss (for the Federal Deposit Insurance Corporation) and John R. Righter (for federal pay), and Mark Booth (for the Federal Reserve). The CBO staff contact for the state and local impact is Leo Lex.

Sincerely,

JUNE E. O'NEIL, *Director.*

Enclosure.

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

H.R. 1836—Federal Employees Health Care Protection Act of 1998

Summary: H.R. 1836 would modify the administration of the Federal Employees Health Benefits (FEHB) program, transfer the health coverage of retirees and certain active employees of the Federal Deposit Insurance Corporation (FDIC) and the Board of Governors of the Federal Reserve to the FEHB program, and raise the pay of certain physicians employed by the federal government. CBO estimates that the legislation would reduce direct spending by $54 million and federal revenues by $7 million over the 1999–2003 period. Consequently, pay-as-you-go procedures would apply to the legislation. In addition, CBO estimates that implementing H.R. 1836 would increase discretionary outlays by $30 million over the 1999–2003 period, assuming appropriation of the necessary amounts.

H.R. 1836 would expand a preemption of state and local authority to regulate health care plans that provide coverage under FEHB. This preemption would be considered a mandate under the Unfunded Mandates Reform Act (UMRA). However, because the preemption would simply limit the application of state law in some circumstances, CBO estimates that any costs to state or local governments arising from this mandate would be minimal. H.R. 1836 contains no private-sector mandates as defined in UMRA.

Estimated Cost to the Federal Government: The estimated budgetary impact of H.R. 1836 is shown in the following table. This estimate assumes that the legislation will be enacted by the start of fiscal year 1999. The legislation would effect governmental receipts and outlays in several budget functions.

[By fiscal year, in millions of dollars]

	1998	1999	2000	2001	2002	2003
CHANGES IN DIRECT SPENDING						
FDIC:						
Estimated budget authority	0	0	0	0	0	0
Estimated outlays	0	160	−14	−15	−18	−20
FEHB:						
Estimated budget authority	0	−178	6	7	8	10
Estimated outlays	0	−178	6	7	8	10
Total Changes in Direct Spending:						
Estimated budget authority	0	−178	6	7	8	10
Estimated outlays	0	−18	−8	−8	−10	−10
CHANGES IN REVENUES						
FEBH Coverage for Federal Reserve:						
Estimated revenues	0	−11	1	1	1	1
SPENDING SUBJECT TO APPROPRIATION						
Spemding on Physicians Comparability Allowance Under Current Law:[1]						
Estimated budget authority	27	27	27	27	14	0
Estimated outlays	27	27	27	27	14	1
Proposed changes:						
Estimated authorization level	0	7	9	9	5	0
Estimated outlays	0	7	9	9	5	([2])
Spending on Physicians Comparability Allowance Under H.R. 1836:						
Estimated authorization level	27	34	36	36	19	0
Estimated outlays	27	34	36	36	19	1

[1] Under current law, agencies can offer allowances to physicians through fiscal year 2000, with the contracts for such allowances extending through fiscal year 2002.
[2] Less than $500,000.

Basis of estimate: By modifying the health coverage of FDIC and Federal Reserve retirees and active employees within five year of retirement, H.R. 1836 would affect both direct spending (for the FIC and the FEHB program) and revenues (for the Federal Reserve). In addition, increasing the pay of certain physicians employed by the government would affect discretionary spending.

Direct spending and Revenues

Health Insurance Transfer for Certain Employees. H.R. 1836 would transfer the health insurance coverage of retirees and certain active employees of the FDIC and the Board of Governors of the Federal Reserve System to the FEHB program. Currently, those two agencies operate their own health insurance programs. The legislation would also require the two agencies to make a one-

time payment to the Office of Personnel Management (OPM), which administers the FEHB program, to cover the long-term cost of the government's contribution toward the insurance premiums of the newly covered individuals.

The shifting of the FDIC employees and retirees to the FEHB program would reduct direct spending in each year because the FDIC pays more for health insurance than the FEHB program would. The current FDIC plan is more expensive that the typical FEHB plan because the insured employees are older and fewer in number, and it provides more general coverage. Ongoing savings would grow form an estimated $7 million in fiscal year 1999 to $11 million in 2003. CBO assumes that the FDIC would make the required one-time payment to OPM in January 1999. We estimate that the one-time payment would be $170 million; but we also estimate that the FDIC would save $10 million in the same year from lower health insurance costs. The net cost to the FDIC in 1999, therefore, would be $160 million. Reflecting the transfer from the FDIC, the FEHB program would receive the payment of $170 million in that year but would incur additional costs of about $3 million to insure those employees and retirees, for new savings of $167 million to the FEHB program.

The transfer between the Federal Reserve and the FEHB program would have a similar effect, but significantly fewer employees would be affected at the Federal Reserve. We estimate that the Federal Reserve would make a one-time payment of $12 million to OPM in 1999, with associated savings of $1 million, for a net reduction in revenues of $11 million. The associated savings to the Federal Reserve and costs to the FEHB program beyond 1999 would both approximate $1 million per year, although FEHB costs may be slightly less and the Federal Reserve's savings slightly more. Also, the budgetary effects on the Federal Reserve are recorded on the revenue side of the budget. Thus, the resulting increases in federal revenues beyond 1999 would approximate the increase in FEHB costs for coverage of Federal Reserve personnel, and the net budgetary impact each year would be negligible.

Other Provisions. CBO estimates that the other provisions of H.R. 1836 would not significantly affect FEHB spending. The legislation would strengthen OPM's ability to bar or sanction unethical health providers and expand a preemption of state and local authority to regulate health plans that provide coverage under FEHB. Enacting those provision might reduce FEHB costs slightly.

H.R. 1836 also would require OPM to encourage carriers to seek assurances that health care providers who contract with third parities to provide discounted rates are made aware of the conditions for those discounts. That provision could discourage some FEHB plans from using certain discount vendors, potentially increasing costs. Based on a survey conducted by OPM, however, FEHB plans believe that their discount vendors disclose the conditions of the discount to health care providers.

Finally, section 8 would allow plans to make direct payments to certain non-physician providers, even when such arrangements are not required by law. Because plans already have such authority, the enactment of that section would not affect FEHB spending.

Spending subject to appropriation

H.R. 1836 would increase the maximum annual allowance payable to eligible federal physicians to $30,000. Current law authorizes certain agencies to pay allowances of up to $20,000 a year to recruit and retain physicians for certain positions, such as those with long-term vacancies or high turnover rates. To receive the allowance, physicians must agree to work at least one year at the agency. CBO estimates that increasing the maximum annual allowance from $20,000 to $30,000 would increase salary costs by $30 million over the 1999–2003 period. This estimate is based on information provided by OPM, including data on the number of federal physicians receiving comparability allowances and the average annual premium that they receive under current service agreements. CBO estimates that the provision would increase the average allowance for 1,800 physicians by about $5,000 a year and that agencies would modify service agreements with physicans within the few months of fiscal year 1999.

The authority for agencies to offer allowances to physicians was extended through fiscal year 2000 by the Treasury and General Government Appropriations Act for fiscal year 1998 (Public Law 105–61). Under that authority, agencies and physicians can enter into contracts that extend through the end of fiscal year 2002. Most service agreements are made for two years. CBO assumes that the number of outstanding contracts in fiscal year 2001 will approximate the number of contracts in 2000, and that the number of contracts in fiscal year 2002 will be about one-half of the number estimated for 2001. Thus, the increase in costs for fiscal year 2002 is lower than for previous years.

Pay-as-you-go consideration: The Balances Budget and Emergency Deficit Control Act of 1985 sets up pay-as-you-go procedures for legislation affecting direct spending or receipts. The net changes in outlays and governments receipts that are subject to pay-as-you-go procedures are shown in the following table. For the purposes of enforcing pay-as-you-go procedures, only the effects in the current year, the budget year, and the succeeding four years are counted.

The budget excludes from pay-as-you-go calculations expenses associated with maintaining the deposit insurance commitment. CBO assumes that the increase in costs to the FEHB program and the decreases to the FDIC from its employees joining the FEHB plan would be excluded from the pay-as-you-go calculations because they would be associated with maintaining the deposit insurance commitment. The budgetary effects on the Federal Reserve, and the corresponding effect on outlays of the FEHB program, would not be excluded.

[By fiscal year, in millions of dollars]

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Changes in outlays	0	−11	1	1	1	1	1	1	1	1	1
Changes in receipts	0	−11	1	1	1	1	1	1	1	1	1

Estimated impact on state, local, and tribal governments: H.R. 1836 would add language expanding the preemption of state and local authority to regulate health care plans that provide coverage

under the FEHB program. Current law prohibits state and local governments from regulating the nature and extent of coverage and benefits for people covered by the FEHB program if the regulation of law is inconsistent with the contract provisions. The new language would preclude state and local governments from regulating the provision of coverage or benefits as well, and it removers the language dealing with inconsistencies, thereby giving the federal contract provisions clear authority. These changes would affect states that have requirements governing what types of organization can provide health care when those requirements are different from those under federal contracts. This preemption would be considered a mandate under UMRA. However, because the only effect of the preemption would be to limit the application of state law in some circumstances, CBO estimates that any costs to state or local governments arising from this mandate would be minimal.

Estimated impact on the private sector: H.R. 1836 contains no private-sector mandates as defined in UMRA.

Previous CBO estimate: On November 3, 1997, CBO prepared a cost estimate for H.R. 1836, as ordered reported by the House Committee on Government Reform and Oversight on October 31, 1997. For the House version of H.R. 1836, CBO did not estimate any effect on direct spending or governmental receipts. This estimate corrects that error.

Estimate prepared by: Federal Costs: Tom Bradley, FEHB, Mary Maginniss, FDIC, Mark Booth, Federal Reserve, and John R. Righter, federal pay.

Impact on State, local, and Tribal governments: Leo Lex.

Estimate approved by: Robert A. Sunshine, Deputy Assistant Director for Budget Analysis.

VI. Evaluation of Regulatory Impact

Pursuant to the requirement of paragraph 11(b) of rule XXVI of the Standing Rules of the Senate, the Committee has considered the regulatory and paperwork impact of H.R. 1836. The Committee reports that section only 3 of H.R. 1836, making technical changes regarding national plans, would result in a mandate, but costs to state and local government have been estimated by CBO to be minimal. Provisions of the bill relating to health insurance [section 3(c)] would preempt all State and local laws that relate to health insurance or plans. Section 2 of H.R. 1836 should reduce administrative burdens on the Office of Personnel Management by streamlining the debarment process. In general, OPM would be permitted to debar a provider prior to a hearing being held. Section 4 of H.R. 1836 would reduce the administrative burdens on both the Federal Reserve and the FDIC by enabling them to avoid maintenance of a non FEBH program plan for Federal Reserve and FDIC employees currently ineligible for FEHBP coverage. Under H.R. 1836, these ineligible individuals will be offered FEHBP coverage at no cost to the Federal government.

VII. Additional Views of Senators Cochran, Glenn, and Levin

At the request of the House Subcommittee on Civil Service, the Office of Personnel Management Inspector General (OPM IG) conducted a study to determine whether silent Preferred Provider Organizations (PPOs) were used by Federal Employee Health Benefit Plan (FEHBP) carriers to capture discounts to which they were not entitled. In brief, the IG found no evidence that health care providers were being victimized by FEHBP carriers, nor any evidence of schemes allowing payers to capture discounts they are not contractually entitled to receive. Although we support inclusion in H.R. 1836 of section 5 bill language, we believe Congress should be careful to avoid interjecting the federal government into contractual issues between health care providers and health plans.

A recent audit by the OPM IG defined "Silent" PPOs as a health care provider discount taken by a FEHBP carrier without a contract existing between the PPO and the health care provider. This is the type of unethical practice that the FEHBP carriers should avoid.

Further, PPOs, both directed and non-directed, provide various incentives to health care providers which contract with PPOs for the benefit of FEHBP, i.e., to reduce health care costs. The FEHBP must continue to benefit from these relationships, recognizing that the PPOs must always have a contract with the health care provider.

Attached is the February 26, 1998 report of the OPM IG, as submitted to Congress, by Patrick E. McFarland, Inspector General, Office of Personnel Management.

Carl Levin.
John Glenn.
Thad Cochran.

OFFICE OF PERSONNEL MANAGEMENT,
Washington, DC, February 26, 1998.

Hon. THAD COCHRAN,
Chairman, Subcommittee on International Security, Proliferation and Federal Services, Senate Committee on Governmental Affairs, Washington, DC.

DEAR CHAIRMAN COCHRAN: As a result of interest initially expressed by Chairman Mica, House Subcommittee on Civil Service, Committee on Government Reform and Oversight, the Office of Personnel Management (OPM), Office of the Inspector General (OIG) has performed a review of the use of "silent" and "non-directed" Preferred Providers Organizations (PPOs) in the Federal Employees Health Benefits Program (FEHBP). Our report is enclosed. The committee expressed the concerns of the American Hospital Association and American Medical Association who suggested that health care providers are being victimized by schemes that create payment discounts for payers who are not entitled to them. These schemes are purportedly carried out by "silent PPOs." Thus, the principal purpose of our review was to determine whether "silent PPOs" were used by FEHBP carriers to capture discounts to which they were not entitled. Our review did not disclose any evidence that FEHBP carriers used "silent PPOs" to capture discounts or that health care providers were otherwise victimized by FEHBP carriers. Nevertheless, we observed that for 1.3 percent of the claims we tested, discounts taken were inconsistent with agreed upon contract terms. We do not consider these errors to be material nor are they indicative of a systemic problem.

At the request of the committee, we also determined how wording in OPM's annual carrier call letter, which encouraged carriers to seek discounts on providers' bills, came to be included in the call letter. We found that the wording was included as a result of discussions between House Appropriation Committee's staff and OPM's former Associate Director for Retirement and Insurance.

A copy of this report has been sent to Representative Dan Burton, Chairman, Committee on Government Reform and Oversight. If you need any additional information related to this review, please call me, or have a member of your staff call Harvey D. Thorp, Assistant Inspector General for Audits.

Sincerely,

PATRICK E. MCFARLAND, *Inspector General.*

Enclosure.

REPORT OF REVIEW

OFFICE OF THE INSPECTOR GENERAL
OFFICE OF PERSONNEL MANAGEMENT

REPORT ON THE USE OF SILENT PPOs
IN THE
FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

REPORT NUMBER 99-00-97-054 DATE February 26, 1998

Harvey D. Thorp
Assistant Inspector General for Audits

Report Number 99-00-97-054

OFFICE OF THE INSPECTOR GENERAL
OFFICE OF PERSONNEL MANAGEMENT

REPORT ON THE USE OF SILENT PPOs IN THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

I. INTRODUCTION AND SUMMARY OF RESULTS

As a result of interest initially expressed by Chairman Mica, House Subcommittee on Civil Service, Committee on Government Reform and Oversight, the Office of Personnel Management (OPM), Office of the Inspector General (OIG) has performed a review of the use of "silent" and "non-directed" Preferred Providers Organizations (PPOs) in the Federal Employees Health Benefits Program (FEHBP). The committee expressed the concerns of the American Hospital Association and American Medical Association who suggested that health care providers are being victimized by schemes that create payment discounts for payers who are not entitled to them. These schemes are purportedly carried out by "silent PPOs." Thus, the principal purpose of our review was to determine whether "silent PPOs" were used by FEHBP carriers to capture discounts to which they were not entitled. Our review did not disclose any evidence that FEHBP carriers used "silent PPOs" to capture discounts or that health care providers were otherwise victimized by FEHBP carriers. Nevertheless, we observed that for 1.3 percent of the claims we tested, discounts taken were inconsistent with agreed upon contract terms. We do not consider these errors to be material nor are they indicative of a systemic problem.

At the committee's request, we also determined how wording in OPM's annual carrier call letter, which encouraged carriers to seek discounts on providers' bills, came to be included in the call letter. We found that the wording was included as a result of discussions between the House Appropriation Committee's staff and OPM's former Associate Director for Retirement and Insurance.

A detailed discussion of our review objectives, scope, and methodology is presented in Section IV. Substantive comments made in response to a draft of this report from several affected parties are included in the appendix.

II. BACKGROUND

The FEHBP was established by the Federal Employees Health Benefits Act (Public Law 86-382), enacted on September 28, 1959. The FEHBP was created to provide health insurance

benefits for federal employees, annuitants, dependents, and others. OPM's Retirement and Insurance Service has overall responsibility for administration of the FEHBP. The provisions of the Federal Employees Health Benefits Act are implemented by OPM through regulations which are codified in Title 5, Chapter 1, Part 890 of the Code of Federal Regulations (CFR). Health insurance coverage is made available through contracts with various health insurance carriers that provide either service benefits, indemnity benefits, or comprehensive medical services. Health insurance carriers provide these benefits on either a fee-for-service or a prepaid basis. For calendar year 1997, there were 14 fee-for-service plans and about 460 prepaid plans in the FEHBP. In a fee-for-service plan, the medical provider is paid a fee for the specific service provided. The size of the fee will vary depending on the complexity of the service. The subscriber's group insurance premiums reflect the composite cost of all fees paid to medical providers on behalf of all subscribers in the group. In a prepaid plan, the providers are generally paid a fixed amount which is intended to cover all the services required by individual subscribers. Because of the fixed nature of the payment, the providers are at risk of not recovering all their costs. This risk is an incentive for prepaid plans to control their costs.

During the last decade, the health insurance industry has been undergoing rapid change in response to rising costs. The rapid growth of prepaid health carriers, generally referred to as Health Maintenance Organizations (HMO), who, through their ability to better control costs via utilization control and managed care techniques, have caused fee-for-service carriers to seek better ways and means to control their costs so that they can remain competitive. One cost control method used by fee-for-service carriers is known as a Preferred Provider Organization (PPO). A PPO is a group of medical providers who agree to provide medical services to the subscribers of an insurance carrier at a lesser cost than would have been otherwise charged. The perception is that in a traditional PPO, the PPO would employ some method of controlling benefit utilization by subscribers and would manage medical care more cost effectively. They might also establish controls to improve the quality of care. In exchange for a preferred status, lower fees, and better care, the carrier would attempt to steer its subscribers to the PPO's medical providers through such methods as financial incentives, ID cards, and preferred provider lists. Thus, significant savings could be achieved by the carrier which would reduce its premium costs.

In recent years, a new variation of the PPO concept appeared. This variation is known as a "non-directed" PPO as distinguished from the traditional PPO which has become known as a "directed" PPO. The terms "directed" and "non-directed" are references to the steerage or lack of steerage of patients. As explained above, in a traditional directed PPO arrangement, subscribers are steered to the PPO to take advantage of the lower costs. In a "non-directed" PPO, even though the medical providers have agreed to charge a lower fee, the contract the PPOs enter into do not require that the carrier's subscribers be steered to them. In some non-directed PPOs, the PPO may benefit from this arrangement as a result of prompt payments or advances. In other non-directed PPO arrangements, the benefits to the provider may be less clear.

In the case of both the directed and non-directed PPOs, the terms of the arrangement are committed to a contract between the parties. Also, there may be intermediate organizational

layers between the insurance carrier and the providers of medical service. In a typical non-directed arrangement in the FEHBP, an insurance carrier contracts with a third party vendor for non-directed PPO services. The vendor assembles the network of non-directed PPO providers by either contracting directly with individual medical providers or by contracting with networks of medical providers who in turn contract with individual medical providers (Exhibit 1). Very frequently, the vendors and the provider networks also contract with other carriers for directed PPOs. Therefore, non-directed PPO services may be provided to FEHBP carriers while directed PPO services may be provided by the same provider or provider network to non-FEHBP insurance carriers.

Concurrent with the evolution of non-directed PPOs, a new term, "silent PPO" became commonplace. The term, "silent PPO," means different things to different people. Initially, the term "silent PPO" was merely a reference to a non-directed PPO where the contract was "silent" with regard to the steerage of patients to the provider's facilities. However, in more recent times, the term has acquired a more restrictive meaning. As a result, to some people, "silent PPO" describes a payment scheme used to obtain illegal discounts for payers who are not entitled to them. In discussions with interested parties and in industry literature, the terms "fraud," "illicit," "manipulation," "falsely," "unethical," and "scheme" are frequently used to describe silent PPOs. Consequently, the term "silent PPO" has come to mean an unethical and/or illegal practice, and the term has been loosely extended to inappropriately encompass non-directed PPOs. For the purpose of our review, we have differentiated between the terms "non-directed PPO" and the more restrictive term "silent PPO." Since "silent PPO" activity would be inappropriate for the FEHBP, we were concerned with the implication that it may exist in the FEHBP.

A "silent" PPO is distinguished from a "non-directed" PPO by the nature of the contractual relationship between the parties. As stated above, in a "non-directed" relationship, discounts are taken pursuant to contractual arrangements that can be traced from the payer (i.e., the insurance carrier) to the medical provider. In a "silent PPO," a contractual relationship can not be traced from the payer to the medical provider from whom the discount is taken. Typically, in a silent PPO arrangement, another PPO will sell its medical provider's names and discounted fee information, often without the provider's knowledge and permission, to a secondary market of vendors. These vendors then access the information on behalf of their payer clients, recalculating the provider's fee based on the discounted fee information. It has been alleged that sometimes, the payer may claim a non-existent affiliation with the provider by inaccurately declaring that the patient is a member of a PPO to which the provider is a member.

In 1993, when the distinction between a non-directed PPO and a silent PPO was less clear, OPM became aware of market place arrangements that resulted in the capturing of discounts from provider bills. As a result, in its March 1993 call letter to FEHBP carriers providing rate and benefits instructions for the 1994 contract year, OPM stated, "In addition, OPM is aware that price concessions are available from non-network providers, e.g., hospitals, so carriers are expected to obtain the lowest price available for all goods and services, including non-PPO

providers." The committee is concerned that this OPM requirement may have encouraged the use of improper payment discounts thereby causing an FEHBP provider to grant a discount to a payer that it is not contractually obligated to give.

III. DISCUSSION OF RESULTS

Our review disclosed that substantial savings have been and can be achieved by both directed and non-directed PPOs. We further found these saving can be achieved in an ethical manner; in that, we found no evidence in the FEHBP that "silent PPOs" were a factor or that provider discounts were otherwise taken on the basis of any schemes to victimize medical providers. In addition, we found FEHBP carriers and their vendors were, except for some minor exceptions, accessing discounts in accordance with the terms of their contracts with providers. Based upon the aggregate of our observations, we believe given the complex environment in which PPOs operate, it is understandable why the expectations for patient steerage by medical providers is not always fulfilled. With regard to OPM's call letter, we found that language which encouraged carriers to seek discounts on providers' bills was the result of discussions between the House Appropriation Committee's staff and OPM's former Associate Director for Retirement and Insurance.

A. Substantial Savings Can Be Achieved through both Directed and Non-directed Preferred Provider Arrangements.

As we indicated earlier, a principal reason why carriers enter into preferred provider arrangements is to reduce their costs. Lower costs translate into lower premiums for the FEHBP, the federal government, and its employees. In our survey of FEHBP carriers, we asked carriers how much the FEHBP saved by using directed and non-directed PPOs. Carriers reported substantial savings (See Exhibit 3). The great majority of the savings were realized under directed PPO arrangements. For the six-month period ending June 30, 1997, six carriers reported gross directed PPO savings totaling $390.5 million. This represents 19.7 percent of premiums for those carriers. For the same period, a different mix of six carriers reported gross non-directed PPO savings totaling $25.5 million representing 2.2 percent of premiums. We conclude that substantial sums can be saved through directed and non-directed PPO arrangements. In view of the fact that directed PPOs provide for steerage of patients, as would be expected, directed PPO savings are significantly larger than non-directed PPO savings. While non-directed PPO savings are substantially lower than directed PPO savings, in absolute terms, they too are significant and offer additional opportunities to reduce FEHBP costs that should not be overlooked, assuming they can be achieved in an ethical and lawful manner.

B. No Evidence Found to Confirm the Use of Payment Schemes that Victimize Health Care Providers in the FEHBP.

Based on our test of insurance benefits paid in August 1997 by FEHBP carriers, we found no evidence that "silent PPOs" were used as a method of capturing discounts or that providers were

being otherwise victimized.

The Committee on Government Reform and Oversight has expressed the concern that medical providers are perhaps being victimized by an alleged practice which accesses provider discounts using subterfuge or misrepresentation. As explained previously, this practice involves the selling of provider names, and the discounts they provide to their directed PPO clients, to third parties who access the discounts by misrepresenting their subscribers as members of the provider's directed PPO. This report uses the term "silent PPO" to describe this practice. In these cases, there is no contractual relationship between the payer of insurance benefits (or their subcontractors) and the medical providers who are providing the medical services to the payer's subscribers. Such misrepresentation, in our opinion, would constitute, at the very least, an unethical practice in the FEHBP. OPM regulations set forth the minimum standards for health benefit carriers. The standards provide that carriers must perform the contract in accordance with prudent business practices which include, "Legal and ethical business and health care practices." (48 CFR 1609.70(b)(2)). Failure to adhere to minimum standards could be cause for terminating a carrier contract. Consequently, the principal focus of our review was to determine whether any FEHBP carriers, or their subcontractors on behalf of FEHBP carriers, participated in the above described practice.

As explained in the background section, the terms "non-directed PPO" and "silent PPO" have been used interchangeably. Therefore, it was generally thought that those vendors who offer non-directed PPOs also made use of "silent PPOs." Consequently, to search for the use of silent PPOs in the FEHBP, we focused our attention on the vendors who subcontract with FEHBP carriers to provide non-directed PPO services. As a result, we identified five FEHBP carriers who contracted with four (as a result of an acquisition, to become three) vendors to provide non-directed PPO services (See Exhibit 2). [Note: These same vendors may also provide directed PPO services to other clients.] We sampled and reviewed 600 claim lines representing 120 claim lines for each carrier that were repriced by these vendors. The purpose of our sample was to determine whether the discount taken on each claim was pursuant to the medical providers membership in the non-directed PPO and was otherwise consistent with their contract. We found that in each instance, a series of contractual agreements were in place. These agreements were between the carrier and the vendor, the vendor and provider network or the provider, and the provider network and providers. Consequently, we found no evidence that the FEHBP carriers through their vendors used "silent PPOs" to access discounts.

C. With Minor Exception, Discounts Were Accessed in Accordance with Contract Terms.

In addition to ensuring that there was a contractual relationship between all the parties who participated in arranging for the discounts from non-directed PPOs, we also verified that discounts taken were consistent with the contract terms. While the great majority of the claim lines tested were processed in accordance with contract terms, we observed in a few instances, that the FEHBP carrier was not entitled to the discounts taken. We found that the vendors accessed provider discounts in 8 of the 600 claim lines (or 1.3%) that were inconsistent with

contract terms. These improperly taken discounts totaled $675.27 representing 1.24 percent of the $54,370 of discounts taken in our August 1997 sample of 600 claim lines. If our findings for the month of August 1997, were representative of the six-month period ending June 30, 1997, then out of carrier reported non-directed PPO savings of $25.4 million, about $315 thousand was improperly taken. In each case, to access the discount, the contract between either the vendor and provider network or between the provider network and the provider required the steerage of the patient to the provider through some form of financial incentive. In each case, the patient was not steered to the provider in accordance with the contract terms. Our review at each vendor is further discussed below:

National Preferred Providers Network (NPPN), Inc.

The NPPN is located in Middletown, New York and offers provider networks to its clients. Its network consists of 3,000 hospitals, 18,000 ancillary facilities, and 280,000 physicians. The NPPN contracts with the National Association of Letter Carriers Health Benefit Plan (NALC) to provide a non-directed PPO network. Their agreement provides that NALC is under no obligation to notify participants of the availability of NPPN's network providers.

During our review of the NPPN claim line sample (60 claim lines out of a universe of 33,848), we determined that there were contractual agreements in place that made the medical providers members of NPPN's network. However, we found that NPPN extended some discounts to NALC that we determined were improper. NPPN's contract with one provider network required steerage in order for the discounts to be given to the insurance carrier. This contract covered three claim lines or 5 percent of the claim lines reviewed in our NPPN sample (See Exhibit 4). For the three claim lines, $55.77 in discounts were taken.

Multiplan

Multiplan is located in New York, New York. It is a facility-based preferred provider organization with a network of over 30,000 hospitals and other facilities located throughout the United States. Multiplan contracts with the NALC to provide a non-directed PPO network. Multiplan also provides directed PPO services to other clients. (See appendix for Multiplan comments.)

During our review of the Multiplan claim line sample (30 claim lines out of 6,081), we determined that there were contractual agreements in place that made the medical providers members of Multiplan's network. Generally, we also found that Multiplan agreements with provider networks did not require the steerage of patients, but instead required Multiplan to use its best efforts to encourage appropriate incentives to the Providers. However, we found that Multiplan extended an immaterial discount to NALC from one provider network that we determined was improper (See Exhibit 4). Multiplan's contract with one network required steerage in order for the discounts to be given to the insurance carrier. The contract covered one claim line or 3.33 percent of the lines reviewed. The discount totaled $1.87.

United Payors & United Providers (UP & UP)

The UP & UP is located in Rockville, Maryland. UP & UP provides non-directed PPO services to the following five FEHBP carriers: Foreign Service, APWU, NALC, Rural Carriers, and SAMBA. In September 1997, UP & UP acquired America's Health Plan, Inc.. AHP previously provided non-directed PPO services to FEHBP carriers. (See appendix for UP & UP comments.)

During our review of the UP & UP claim line sample (510 claim lines out of 40,704), we determined that there were contractual agreements in place that made the medical providers members of UP & UP's network. We observed that UP & UP periodically provides its provider networks with a list of client payers. They also provide their hospitals with a cash prepayment. We also noted that UP & UP agreements state that it will use its best efforts to require each payer client to create financial incentives for covered persons to utilize their providers.

Our review disclosed that UP & UP accessed discounts for four APWU claims that we determined were improper (See Exhibit 4). For the four APWU claim lines, one contract between a provider network and its providers required steerage of subscribers through financial incentives in order for the discounts to be given to the insurance carrier. In all four cases, the carrier did not provide the financial incentives required by the contract. In three of the four cases, the APWU paid 100 percent of the claim. Had co-insurance been applicable to these specific claims, the cost sharing provision of UP & UP's contract with its providers would have been operative thereby authorizing the discounts taken. These four claim lines represent less than one percent of the claim lines reviewed in our sample. The discounts taken total $617.63.

Conclusion

While we found no evidence that silent PPO's were a problem in the FEHBP, we noted that in eight instances, FEHBP carriers were given access to discounts by their vendors to which they were not entitled. In these instances, the contracts with either the provider networks or the providers required a financial incentive to steer patients to the provider's facilities and the subscribers were not so steered. We believe it is the obligation of the vendor to ensure that it does not give FEHBP carriers access to discounts to which they are not entitled. To the extent that these circumstances exist, providers would have cause for concern. However, the number of instances in our sample were not material.

While the evidence of our review suggests little cause for concern, this conclusion is inconsistent with the level of concern expressed by the medical community. While we found that in the great majority of the cases, discounts taken were consistent with the contract terms, the complex environment and sometimes vague contract terms under which PPOs operate leave expectations on the part of providers that perhaps are not being fulfilled. First, we observed that many of the vendor contracts with provider networks and providers state that the vendor will make a reasonable or best effort to encourage payers to provide incentives to its subscribers to use the vendor's providers. Best efforts do not always translate into actual steerage. Second, the

contractual relationship between the vendor and the provider sometimes also involves an intermediary, a regional provider network. These regional network agreements insulate the provider from the true nature of the agreement that exist between the regional networks and the vendor. Third, some payer clients use the vendors for directed PPO services and thus share the same providers with other payer clients who use the vendor's non-directed PPO services. Since the vendor may have only a single contractual agreement with the provider, some of the patients are steered and others are not. Thus, we can visualize how these three factors can combine to cause perhaps false expectations and confusion on the part of providers who may be expecting steerage but in fact entered into an agreement that does not require steerage. We would suggest that the best solution to these factors is education within the industry. We have observed that both the American Medical Association and the American Hospital Association have already begun such an effort.

D. Use of Non-directed PPOs Encouraged by Appropriation Committees.

Our review determined that language in OPM's annual carrier call letters, which encouraged carriers to seek discounts on providers' bills, was a result of discussions between House Appropriation Committee's staff and OPM's former Associate Director for Retirement and Insurance.

Each spring, OPM issues its annual carrier call letter to health benefits carriers. The call letter is a solicitation to current FEHBP carriers for proposed rate and benefit changes for the upcoming contract year which begins January 1. The letter generally provides overall direction and sets the parameters for acceptable rate and benefit changes. Recognizing that in the market place, price concessions were available from non-network providers (meaning providers who do not belong to directed PPO networks), the March 1993 call letter for the 1994 contract year included a new provision which encouraged carriers to obtain price concessions from providers including non-PPO providers (again meaning providers who do not belong to directed PPO networks). The provision read as follows:

> "Carriers are to actively establish or promote the expansion of existing PPO arrangements in terms of availability to enrollees as well as coverage provided. In addition, OPM is aware that price concessions are available from non-network providers, e.g. hospitals, so carriers are expected to obtain the lowest price available for all goods and services, including non-PPO providers." (Underline added)

A similar provision was included in the March 1994 call letter for contract year 1995. It read as follows:

> "We continue to encourage expansion of PPO arrangements, in terms of availability of PPO providers to enrollees and coverage provided. In addition, carriers are expected to obtain the lowest price available for all goods and

> services, including those of non-PPO providers. All carriers must put in place procedures to capture discounts from all bills presented and/or contract with vendors to do this." (Underline added)

The call letters for contract years 1996, 1997, and 1998 continued to encourage carriers to expand and strengthen their existing PPO arrangements and the services provided under such arrangements. In addition, they each contained the following pertinent provision:

> "We also expect carriers to put in place procedures to capture discounts from bills presented, where cost effective to do so."

The committee was concerned that the call letter language may have encouraged, perhaps inadvertently, the use of improper payment discounts. By "improper," they meant any system of payment discounts for payers who are not entitled to such discounts. They believed that the result of any such improper discount would be to cause an FEHBP provider to grant a discount to a payer that it is not contractually obligated to give. The committee was also concerned that the call letter seems to have had the effect--intended or not--of spawning efforts on the part of some network managers and/or brokers to require the use of non-directed PPOs by statute. As a consequence, the committee asked us to determine what prompted the language in the OPM call letter.

The former Associate Director for Retirement and Insurance recollected that in 1993 the House Appropriation Committee was considering either report or statutory language which would require FEHBP carriers to take advantage of provider discounts available in the market place. The former Associate Director indicated that he opposed any language which would regulate the market place. Consequently, as a compromise he agreed to include language in OPM's call letter which would encourage FEHBP carriers to take advantage of whatever discount arrangements were available in the market place. In 1993 (for the FY 1994 appropriation) and again in 1994 (for the FY 1995 appropriation), both the House and Senate Appropriation Committee reports on OPM's appropriation bill applauded OPM's action. The House report for the FY 1994 appropriation stated:

> "The Committee feels that, in addition to the cost savings obtained by HMO's and PPO's, all FEHBP carriers should endeavor to obtain the lowest price available for the goods and services they provide. The Committee has learned that while price concessions are available from most providers, not all FEHBP carriers are receiving such discounts. Many carriers in the FEHBP merely pay the billed charges or the usual and customary rate.
>
> The Committee is aware, however, that some carriers are utilizing large discount networks that have negotiated more favorable rates with providers. The Committee feels there could be significant savings realized through a more concerted effort by carriers to pay the lowest price available for billed medical

> charges, and applauds the Office of Personnel Management's reference to such potential efforts in its Letter to Carriers dated March 31, 1993. The Committee believes these efforts should in no way disrupt benefits or attempt to direct patients if they choose not to be directed to specific providers."

Based on our interview with the former Associate Director for Retirement and Insurance and our review of the Appropriation Committees' Report for the Treasury, Postal Service, and General Government Appropriation bills for 1994 through 1995, we conclude that the call letter language was prompted by the House Appropriation Committee.

IV. OBJECTIVES, SCOPE, AND METHODOLOGY

The objective of our review was to determine whether FEHBP carriers were taking advantage of health care providers by using payment schemes that create payment discounts for payers who are not entitled to them. In performing our review, the committee staff requested that we also:

1. Identify organizations that contract with FEHBP carriers to reprice provider bills to obtain a discount where the FEHBP carrier does not have a directed PPO with the provider or the patient has not been given a financial incentive to use the provider from whom the discount was obtained.

2. Determine whether any discounts were taken by FEHBP carriers to which they were not contractually entitled.

3. Identify providers that have a contract with vendors based solely on the possibility of becoming a part of that vendors network.

4. Identify providers that have a contract with a vendor based solely on the concern that they need to do this to remain competitive.

5. Determine what prompted the language in the OPM call letter to encourage the use of non-directed PPOs by FEHBP carriers.

Our review was performed in accordance with generally accepted government auditing standards for performance audits. The review was performed at the Government Employees Hospital Association, Kansas City, Missouri; United Payors and United Providers, Rockville, Maryland; Multiplan, New York, New York; and National Preferred Providers Network, Middletown, New York during the period June 1997 through December 1997. Additional work was performed in our offices in Washington DC. Our review entailed the following review procedures:

- We conducted an initial review at the FEHBP's Government Employees Hospital Association (GEHA) plan to gain an understanding of the subject. We interviewed carrier officials and traced 34 claims, which were repriced by non-directed PPO vendors,

to contractual agreements between the GEHA, vendors, and providers. We found no evidence of questionable conduct or contract inconsistencies; that is, in each case, we found that contracts were in place and that discounts were taken pursuant to the contract terms.

- We surveyed 9 of 14 FEHBP fee-for-service carriers to identify which carriers used directed and non-directed PPOs and to identify the non-directed PPO vendors used by the carriers. We did not survey: Blue Cross Blue Shield (has its own PPO networks), GEHA (covered in survey work), Association Benefit Plan (requires extraordinary security procedures), Panama Canal Area Benefit Plan (out of country), and Secret Service (underwritten by BCBS who has its own PPO networks).

- Of the nine carriers surveyed, we found that five carriers used non-directed PPO arrangements. They were:

  1. American Foreign Service Protective Association (Foreign Service),
  2. American Postal Workers Union Health Plan (APWU),
  3. National Association of Letter Carriers Health Benefit Plan (NALC),
  4. Rural Carriers Benefit Plan (Rural Carriers), and
  5. Special Agents Mutual Benefit Association (SAMBA).

- We identified four vendors that provided non-directed PPO services to the five carriers (See Exhibit 2). They were:

  1. United Payors and United Providers (Up & Up), Rockville, Maryland,
  2. America's Health Plan (AHP), Rockville, Maryland (Acquired by UP & UP),
  3. Multiplan, New York, New York, and
  4. National Preferred Provider Network (NPPN), Middletown, New York.

- From each carrier, we acquired a computer tape of all benefit payments during August 1997. From these tapes, we extracted 80,633 claim lines representing $2.7 million in discounts paid by the five carriers and repriced by one of the four non-directed PPO vendors.

- From the extracted claim lines, we sampled 600 claim lines (120 per carrier) representing $54 thousand in discounts.

- For each of the 600 claim lines, we reviewed the carrier's Explanation of Benefits, when available, traced claims to carrier contracts with vendors and further traced claims to vendor contracts with provider networks and/or providers.

- We reviewed the carrier and provider network contracts at the vendors' offices to determine whether contracts were in place and to determine whether the contracts

required steerage in order to access the discounts. When present in the vendors file, we also examined the provider network's contracts with providers to determine whether steerage was required.

- We recalculated a sample of discounts to verify that discounts were calculated consistent with contract terms.

- We met with representatives from the American Medical Association and the Federation of American Health Systems.

- We did a literature search and reviewed the articles identified.

- We surveyed 30 hospitals that complained to OPM about its call letter provision regarding the capture of discounts.

- With regard to the call letter issue, we reviewed OPM's call letter files for the period 1991 through 1997 and interviewed both the former Deputy and Associate Directors for Retirement and Insurance Services to determine who or what influenced OPM to include in its annual call letter a statement which would encourage carriers to capture discounts from non-PPO medical providers. We also reviewed the House and Senate Appropriation Committee Reports for the Treasury, Postal Service, and General Government Appropriation bills for 1993 through 1995.

Due to time constraints, we were not able to perform sufficient procedures to identify health care providers that entered into a non-directed PPO contract arrangement with a vendor based solely on the possibility of becoming a part of that vendor's directed PPO network or to remain competitive. While we did make some limited inquires, those inquires were insufficient to either confirm or deny whether these were substantive reasons for entering into a non-directed PPO arrangement.

EXHIBIT 1

FLOW OF DISCOUNT ARRANGEMENTS

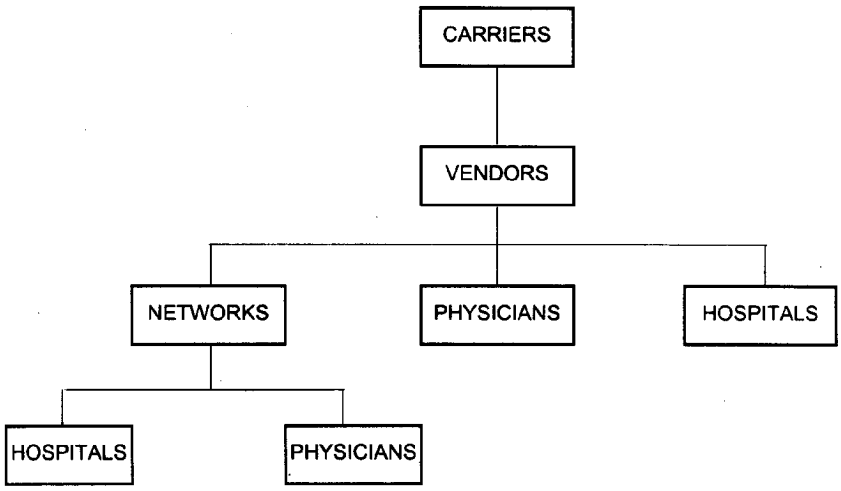

EXHIBIT 2

PREFERRED PROVIDER ORGANIZATIONS

Employee Organization	Multiplan, Inc	National Preferred Provider Network	United Payors & United Providers and America's Health Plan
American Foreign Service Protective Association			✔
American Postal Workers Union Health Plan			✔
National Association of Letter Carriers Health Benefit Plan	✔	✔	✔
Rural Carrier Benefit Plan			✔
Special Agents Mutual Benefit Association			✔

Vendors:

Multiplan, Inc.
115 Fifth Avenue
New York, NY 10003
Phone: (212) 780-2000

National Preferred Providers Network, Inc.
407 East Main Street
Middleton, NY 10940
Phone: (914) 343-1600

United Payor and United Providers/America's Health Plan
2275 Research Boulevard, Sixth Floor
Rockville, MD 20850
Phone: (301) 548-1000

EXHIBIT 3

PREFERRED PROVIDER ORGANIZATIONS REVIEW

PREMIUM PAYMENTS
FOR PERIOED ENDING JUNE 30, 1997
(UNAUDITED)

DIRECT PPOs

CARRIER	PREMIUM PAYMENTS	SAVINGS	RATIO
APWU	203,027,700	29,825,317	14.69%
GEHA	477,451,392	106,799,463	22.37%
MHBP	903,996,936	179,148,767	19.82%
NALC	323,256,494	58,873,579	18.21%
POSTMASTER	29,373,621	5,007,328	17.05%
SAMBA	41,255,807	10,839,047	26.27%
Gross	1,978,361,950	390,493,501	19.74%
Fees		29,854,245	
Net	1,978,361,950	*360,639,256	18.23%

NONDIRECT PPOs

CARRIER	PREMIUM PAYMENTS	SAVINGS	RATIO
AFSPA	18,858,169	392,495	2.08%
APWU	203,027,700	2970380	1.46%
GEHA	477,451,392	7573843	1.59%
NALC	323,256,494	12,573,249	3.89%
RURAL	85,536,527	1,630,669	1.91%
SAMBA	41,255,807	311,073	0.75%
Gross	1,149,386,089	25,451,709	2.21%
Fees		4,345,450	
Net	1,149,386,089	21,106,259	1.84%

* Amounts saved may be further reduced as a result of financial incentives given to subscribers.

EXHIBIT 4

Results

Vendors	Arrangement between Vendor/Network	Arrangement between Network/Provider	Total Number of Errors	Total Amount of Sample Errors
National Preferred Provider Network	3		3	$55.77
Multiplan	1		1	$ 1.87
United Payors & United Providers		4	4	$617.63
Total Errors	4	4	8	$675.27
Number of claim lines reviewed			600	$54,370
Error Rate			1.3%	1.24%

APPENDIX

SIGNIFICANT RESPONSES FROM AFFECTED PARTIES

1. William E. Flynn, III, Associate Director for Retirement and Insurance, Office of Personnel Management
2. Richard G. Miles, President, Government Employees Hospital Association, Inc.
3. Carroll Midgett, Chief Operating Manager, Health Plan Department, American Postal Workers Union, AFL-CIO
4. Calvin Engel, Assistant Administrator, National Association of Letter Carriers Health Benefit Plan
5. S. Joseph Bruno, Chief Financial Officer, United Payors & United Providers
6. Sidney L. Meyer, Executive Vice President, MultiPlan

United States
Office of
Personnel Management

Washington, D.C. 20415

In Reply Refer To: Your Reference:

MEMORANDUM FOR PATRICK E. MCFARLAND
INSPECTOR GENERAL

FROM: WILLIAM E. FLYNN, III
ASSOCIATE DIRECTOR
FOR RETIREMENT AND INSURANCE

Subject: Silent PPOs, Report Number 99-00-97-054

Thank you for sharing your "Report on the Use of Silent PPOs in the Federal Employees Health Benefits Program" with us. We were impressed with the rigor and thoroughness of the report and are gratified that it confirmed our belief that the carriers which contract with us engage in lawful and ethical practices in obtaining discounts from health care providers.

We were pleased that the small number, only 1.3 percent, of discounts that occurred in a manner inconsistent with agreed upon contract terms were inadvertent errors which were neither material nor indicative of any systemic problem in need of correction. While much concern has been expressed about "silent PPOs" which take inappropriate discounts from health care providers, your report definitively shows that if "silent PPOs" exist at all, they clearly do not exist in the Federal Employees Health Benefits Program. What do exist are legitimate non-directed PPOs which produce material savings for the carriers that employ them. While these savings do not approach those obtained by the same carriers from their directed PPO networks, they still constitute savings which would not otherwise have been achieved.

We hope that your report will put to rest the need that some parties have expressed for action on our part to address a "silent PPO" problem that does not exist.

GEHA

The Health Plan for Federal Employees

February 16, 1998

Office of the Inspector General
Office of Personnel Management
Attention: Sanders Gerson
Room 6400
1900 E St. N.W.,
Washington, D.C. 20415

Subject: Draft Copy of Report on Silent PPOs

Dear Mr. Gerson:

I have reviewed the report and was relieved to see that the conclusions supported our position on this matter. As a matter of editorial comment only I have a couple of observations from reading the report.

The report discusses the concept of an "ideal" PPO. I believe that the term "ideal" used in this context is too subjective and creates the impression that one type of network is better than another. In reality, what may be desired by a provider may not be ideal from a payor standpoint or from that of another provider.

Although many PPOs do provide services related to controlling utilization this is not universal and the savings derived from utilization controls is minor in comparison to the savings from contractual agreements with providers. In my opinion, whether or not a PPO provides utilization controls is not relevant to the subject matter. I might also suggest that you substitute "traditional" for "ideal" to describe directed networks in the second paragraph on page 2.

I thought the report language could be strengthened to note that although a small number of errors were detected there did not appear to be a systematic practice of deception nor were any of the errors made or a material nature.

Government Employees Hospital Association, Inc.
P.O. Box 1096 • Independence, MO 64051-0596 • Telephone (800) 821-6136
www.geha.com

Overall, I was very pleased with the conclusions reached and am hopeful that this report will put the issue to rest so we can all devote our efforts to more substantive topics. Thank you for giving me the opportunity to review the draft report and to provide comment.

Sincerely,

Richard G. Miles
President

Health Plan Department
American Postal Workers Union, AFL-CIO

P.O. Box 420, Burtonsville, MD 20866

February 17, 1998

Mr. Sanders P. Gerson
Deputy Assistant Inspector General for Audits
Office of Personnel Management
1900 E. Street NW - Room 6400
Washington, D.C. 20415

Dear Mr. Gerson:

We appreciate the opportunity to comment on the Office of Inspector General's report on "Silent PPOs" before its release to the House Committee on Government Reform and Oversight.

Based on a review of the draft report dated February 6, 1998 and discussions with the OIG audit staff, it is our understanding that the four APWU claim lines in question (out of 120 claims reviewed) involved agreements between the hospitals and a network which required steerage of subscribers through financial incentives in order for the discounts to be given. While the contract between APWUHP and UP & UP did not require steerage and the contract between Up & Up and the network did not require steerage, the contract between the network and the providers apparently required steerage.

Currently, the APWUHP is working with UP & UP to determine what alternatives are available to eliminate the conflicting language in the provider - network contracts.

Additionally, the 4 claims lines out of 120 claims reviewed represents a 97% processing accuracy rate which is well above the 95% processing accuracy standard set by the Office of Personnel Management.

February 17, 1998

If you have any questions regarding the enclosed information, you can reach me at (301) 622-5554.

Cordially,

Carroll Midgett

Carroll Midgett
Chief Operating Manager

NATIONAL ASSOCIATION OF LETTER CARRIERS
HEALTH BENEFIT PLAN

20547 Waverly Court, Ashburn, Virginia 20149 • (703) 729-4677
Vincent R. Sombrotto, President • Thomas H. Young, Jr., Director

Delivered via Facsimile and U.S. Mail

February 17, 1998

Office of the Inspector General
U.S. Office of Personnel Management
Room 6400
1900 E Street, N.W.
Washington, DC 20415

Attention: Sanders Gerson, Deputy Assistant Inspector General for Audits

Dear Mr. Gerson:

Thank you for the opportunity to review the Office of the Inspector General's (OIG) preliminary report on silent and/or non-directed PPO type programs. As this report indicates, PPO arrangements are defined and applied by FEHBP carriers with differing methodologies. Because of this, it is difficult to draw a parallel between the FEHBP carrier's PPO type applications.

Reviewing this OIG draft suggests that OIG is only releasing aggregate fees (i.e. the amounts paid to PPO contractors for savings on discounted services) for the FEHBP program. The NALC Health Benefit Plan believes that OIG's final release should not disclose individual negotiated fees with any given vendor - being that they are competitively derived. Releasing these fees will violate the Plan's disclosure terms of PPO agreements and may jeopardize our capability to obtain future competitive bidding with PPO and discounted provider groups.

Again, thank you for giving the NALC Health Benefit Plan an opportunity to review and comment on this report before its final release.

Sincerely,

Calvin Engel
Assistant Administrator

UNITED PAYORS & UNITED PROVIDERS

February 17, 1998

Sanders P. Gerson
Deputy Assistant Inspector General for Audits
U.S. Office of Personnel Management
Office of Inspector General
1900 E Street, N.W., Room 6400
Washington, DC 20415

Dear Mr. Gerson:

Thank you for the opportunity to meet with you and Mr. Gibbons on Friday afternoon regarding the results of the Office of the Inspector General's Review ("OIG Review") of the use of Preferred Provider Organizations ("PPOs") in the Federal Employees Health Benefit Program ("FEHBP"). We, the management team at United Payors & United Providers, Inc. ("UP&UP"), want to reiterate to the OIG that:

(1) The review was performed in a professional and efficient manner with knowledgeable staff.

(2) The OIG's extension of their FEHBP Review to include PPO provider contracts was an important element of examining the benefits derived by the FEHBP. The Review validated the importance of the PPO networks in obtaining savings for not only the FEHBP but also for the individual plan members.

(3) The OIG's Review was an important step in determining that there was "no evidence found to confirm the use of payment schemes that victimize health care providers in the FEHBP". Further, we appreciated your comments at our meeting which indicated that a reader of your Review report should determine that (a) there was no evidence of "Silent PPO" activity, (b) the FEHBP derived significant benefits from PPOs, and (c) there is no need for further audit work by the OIG or any other oversight body regarding the use of PPOs.

We believe that if the FEHBP were to be subjected to a further review, it would be imperative for the OIG, or other agency of the Federal Government, to audit all vendors (so-called Directed and non-Directed PPOs) that provide financial intermediary services between FEHBP payors and health care providers. These intermediaries (PPOs) offer identical products that are utilized by the commercial payor community (i.e., major insurance companies). From our perspective, it is important to note that discounts enjoyed by the FEHBP through so-called Directed PPO products are also supported by a similar

commercial contracts. In fact, if such Directed PPO arrangements were not supported by a valid contract, there would be evidence of a "Silent PPO" and an abusive provider relationship. Specifically, we believe that all other so-called Directed PPOs should be subjected to the same contractual scrutiny that other FEHBP financial intermediaries have experienced. To drive this point home, if there is a need to expand your Review, we believe it should be expanded to the other PPOs serving the FEHBP.

Audit/Review Conclusions Should Be Clearly Stated

We are pleased with the results of your Review and we recommend that your report consist of an opinion paragraph (presented on page 1 of your report) that indicates the scope of your Review and the results obtained as noted in your headline comments A and B on page 6 of your draft report. The substantial background information section of your report inadvertently allows the reader to believe that unverified industry data and processes represent the results of your Review. Specifically, we believe that there is no support for the following health care terminology used in your Report:

- Financial incentives
- Ideal PPO
- Steerage
- Directed PPO
- Non-Directed PPO

If the reader of your Review report requires background information, we suggest an appropriate Appendix which describes how the $1 trillion health care industry operates including the Blue Cross and other so-called Directed PPOs. This write-up should also include common health care terminology and not "hearsay" comments which you describe as anecdotal information from the Committee staff and other special interest groups.

UP&UP is a public company required to make disclosures to the Securities and Exchange Commission, therefore, we are confident that our business would be characterized using the following informational points:

- ✔ UP&UP's clients include all major insurance carriers — Aetna, Cigna, John Hancock, United HealthCare, Prudential, Mutual of Omaha, etc. These clients use the same national health care network as the FEHBP.

- ✔ UP&UP is a financial services company that supports the health care industry. Insurance companies and other major payors design health plans for a full range of large and small group employers, unions and other Government employees that utilize the UP&UP network.

- ✔ UP&UP regularly communicates with its provider clients by describing how the beneficiaries of our payor clients use the provider network.

- ✔ UP&UP's contracts with its providers offer tangible benefits such as a prepayment of one month (1/12) of medical claims represented by all of UP&UP's payor clients. As of December 31, 1997, UP&UP has prepaid approximately $17 million in medical claims.

- ✔ UP&UP has contracted with hospitals, ancillary facilities and physicians that represent "high utilization" providers of the beneficiaries that are covered by the health plans of UP&UP's payor clients.

- ✔ UP&UP's national network product is based on certain principles:

  - UP&UP does not assume underwriting risk
  - UP&UP prepayments to providers do not require the provider to assume business risk (capitated payments do shift risk to the provider)
  - UP&UP facilitates the continued use of the health care provider by the beneficiary through positive communication (directories, 800 numbers, ID cards). "Steerage" to hospitals is done by physicians and UP&UP believes that it is inappropriate to interfere with the doctor-patient relationship.

- ✔ The UP&UP network savings are always shared with the beneficiary. UP&UP believes that the waiver of a "co-payment" is a financial technique that is negative for the following reasons:

  - Interference with the patient's relationship with their physician.
  - Increase in health care costs, i.e.:

	UP&UP Relationship	Co-Payment Waiver Financial Technique
Hospital Bill	$1,000	$1,000
Contractual Allowance	(200)	(200)
Net Billing	800	800
Co-Payment Waiver (20%)	N/A	160
Total Health Care Cost to Payor (80/20 plans)	640	800
Increase Health Care Cost Shifting		20%

Further, as noted above, we believe that when a co-payment waiver is required to "so-called direct" a patient to a specific hospital, the FEHBP actually incurs a significant cost in addition to the PPO network access fee in order to achieve "steerage" (if one actually believes that anyone or anything steers a patient other than a physician).

Full Disclosure of Background Information is Needed to Make the OIG Report Complete

There are references to Chairman Mica, House Subcommittee on Civil Service, in your report. We believe that it would be important background information for Congressman Mica's comments on October 22, 1997 to be included in your report. An excerpt of his comments are:

> "The second major revision in the amendment deals with the most controversial matter in the bill: the question of 'silent PPOs'. Everyone acknowledges that Preferred Provider Organizations (PPOs) play an important role in today's health care market. Frequently, these PPOs negotiate discounted rate schedules with health care providers in exchange for certain incentives. The incentives may include an agreement to steer patients to the provider, in the case of so-called "directed PPOs', or they may include financial incentives such as prepayment or prompt payment in the case of so-called 'non-directed PPOs'. Both directed and non-directed PPOs provide legitimate and valuable benefits to health care providers, carriers, and patients.
>
> However, many believed that the original language placed non-directed PPOs at a competitive disadvantage. That was not Chairman Burton's intent, and it is certainly not the intent of this subcommittee.
>
> 'Silent PPOs', however, are another matter. These organizations take advantage of health care providers by arranging for a carrier to obtain access to discounted rates it is not entitled to. The first victims of this practice are the Doctors and Hospitals. But in the end, all of us will pay the price as the losses incurred by these providers are shifted to other consumers of medical services."

Also, an October 16, 1997 letter to John Mica from Constance A. Morella, M.C., Thomas M. Davis, M.C., Elijah E. Cummings, M.C. and Harold E. Ford, Jr., M.C. indicated that:

> "We are writing to express our collective concerns about Section 5 of H.R. 1836. Currently, fee-for-service plans in the Federal Employees Health Benefits Program (FEHBP) are saving the government millions of dollars a year through their utilization of various savings initiatives, including non-directed efforts. Section 5 of H.R. 1836 would cost the FEHBP these savings and create an administrative burden that would increase administrative costs.
>
> We are concerned about these increased costs to FEHBP, which would be borne jointly by the federal government and federal employees. Already, next year's premiums are rising, on average, by 8.5%. Increased costs caused by this legislation would almost certainly need to be addressed in both authorizing and appropriating legislation if Section 5 is enacted. The Office of Personnel Management (OPM) and carriers within the program have expressed concern over these additional costs. In the Congressional Budget Office's (CBO) first approximation, FEHB costs could increase by between $10 and $50 million a year after 1998 if Section 5 of H.R. 1836 were enacted. The government's share would be approximately 70 percent of that amount, split roughly equally between additional agency costs and government payments for annuitants.
>
> Section 5 would legislate a mandate on the FEHBP, instead of leaving these issues to the marketplace to sort out. Our job is to protect the federal treasury and federal employees – not to become involved in private sector disputes."

Finally, you indicated during a telephone conversation with UP&UP that Congresswoman Morella had asked the OIG a series of questions concerning your Review and the scope of your work. We believe that the entire OIG response to Congresswoman Morella would represent important background data as an Appendix to your report.

Hearsay, Anecdotal Comments and Unsubstantiated Data Do Not Constitute a "Review Opinion"

We previously noted that your background data could easily be confused by a reader of your report to be the results of your Review. We reinforce our comments on the efficiency and effectiveness of your Review and we believe that your "Review Opinion" included in the second paragraph of page 7 of your report should be on page 1, paragraph 1 of your report. Your opinion includes these important factual statements:

> "Our purpose was to determine whether the discount taken on each claim was pursuant to the medical providers membership in a non-directed PPO and was otherwise consistent with their contract. We found that in each instance, a series of contractual agreements was in place. These agreements were between the carrier and the vendor, the vendor and provider network or the provider, and the provider network and providers. Consequently, we found no evidence that the FEHBP carriers through its vendors used silent PPOs to access discounts."

The conclusion section of your report includes many industry statements that may not be universally accepted, terms without an appropriate definition and a conclusion sentence that is inconsistent with your Review opinion on page 7, paragraph 2. Specifically, your conclusion in the first paragraph on page 10 states:

> "Thus, these three factors combine to cause perhaps false expectations and confusion on the part of providers who may be expecting steerage but in fact entered into an agreement that does not require steerage."

The word "confusion" has a negative connotation. Of course a $1 trillion industry has "complex" elements. The providers in question are organizations with billions of dollars in revenue, sophisticated financial staffs and legal counsel representation. It is difficult to believe that they do not understand contractual relationships entered into.

Specific Comments Concerning UP&UP's Review Items

With respect to the four UP&UP "errors" as presented in Exhibit 4, we believe that three of the four items noted are not errors. Our support is as follows:

Monongalia General Hospital

This contract states on page 4, section 3.4, the following regarding incentives:

> "HPO will offer most favorable terms to payors that provide the greatest financial savings for Covered Subscribers to utilize the HPO network. All HPO Network payors provide financial incentives for covered subscribers that utilize the network. Financial incentives range from shared saving arrangements, to reduced or waived co-insurance/deductibles, to benefit differentials and planned design."

This section addresses two items:

(a) Most favorable terms to payors, and
(b) Financial incentives for covered subscribers.

Item (a) refers to offering the payor client a lower fee if they provide greatest incentives to their covered subscribers; while item (b) refers to financial incentives for covered beneficiaries. The contract specifically defines the range of financial incentives from "shared savings to benefit differentials". Our Payor clients utilize "shared savings" to meet the financial incentive contract requirement, **therefore, this does not constitute an "error"**.

Baptist Hospital of East Tennessee (page 4, section 3.4)
East Jefferson General Hospital (page 4, section 3.2)

These contracts state the following regarding incentives:

> "HPO will offer most favorable terms to Payors that provide the greatest financial savings for Covered Subscribers to utilize the HPO network."

The respective sections address "most favorable terms to Payors" and refers to offering the Payor client a lower fee if the Payor provides greatest incentives to their covered subscribers. There are no contractual requirements regarding financial incentives for covered subscribers, **therefore this does not constitute an "error"**. Notwithstanding this, all our Payor clients utilize the "shared savings" financial incentive program for their covered subscribers. If the Payor client implements additional methods of financial incentives such as waived co-insurance and deductibles, benefit differentials, etc., then the fee paid by the payor client to access the network would be reduced.

Specific Comments Regarding Exhibit 3

As currently presented, Exhibit 3 does accomplish the objective stated at our meeting to "demonstrate that utilization of both Directed and non-Directed PPOs benefit the FEHBP program". However, the method in which the information is presented, and certain elements of the information, are unclear, inaccurate and misleading. The unclear, inaccurate and misleading elements are as follows:

(a) Net Direct PPO savings do not reflect the "actual" additional cost to the FEHBP of the financial incentives (reduction or waiver of co-payments/deductibles, etc.); and

(b) Non-Directed PPOs' savings ratio calculations are misleading. Specifically, the amount of premium payment is significantly overstated due to the fact that the premium payment must be reduced by the actual amount applicable to Directed PPOs to avoid double counting.

We have revised Exhibit 3 to reflect a clearer presentation of the data and it is included as an attachment to this letter for your consideration. We believe the revised Exhibit 3 reflects your stated objective "to demonstrate that utilization of both Directed and Non-Directed PPOs benefit the FEHBP program".

* * * * * *

In closing, we apologize if the tone of our comments indicate any displeasure with the Review process by the OIG. In fact, we are pleased that the matter seems to be resolved since your Review indicated that there was no evidence of any "Silent PPO" activity. As a public company, we are sensitive about comments made concerning our business. We operate with strong business principles and our national health care network is used to process approximately $3 billion of medical claims for all major insurance carriers. As a public company, we know we are subject to public scrutiny and we are satisfied with the results of your Review. We do not believe, however, that government oversight should extend into a matter that is clearly governed by contractual relationships.

Thank you again for allowing us to comment on your draft Review report. Of course, we would be pleased if our response (or portions of our response) is included as an Appendix to your final report as background information on the health care industry.

Very truly yours,

S. Joseph Bruno
Chief Financial Officer

SJB/aiw
Attachment

PRELIMINARY REPORT: FOR DISCUSSION PURPOSES ONLY
NOT FOR PUBLIC RELEASE

EXHIBIT 3
(revised)

PREFERRED PROVIDER ORGANIZATIONS REVIEW

PREMIUM PAYMENTS
FOR PERIOD ENDING JUNE 30, 1997

Carrier	Premium Payments	Net Savings	Ratio
APWU	$ 203,207,700		
GEHA	477,451,392		
MHBP	903,996,936		
POSTMASTER	29,373,621		
SAMBA	41,255,807		
AFSPA	18,858,169		
NALC	323,256,494		
RURAL	85,536,527		
Total	$ 2,082,936,646		
Net direct PPO savings (1)		$ 360,639,256	17%
Net non-direct PPO savings		21,106,259	1%
Total		$ 381,745,515	18%

(1) Directed PPO's by definition must utilize a direction mechanism in the form of financial incentives (reduction or waiver of co-payments and/or deductibles for the federal employee). These financial incentives are not included in this analysis as they were not available from the FEHBP Carriers. The impact of these financial incentives would be to reduce net savings since the FEHBP paid a larger portion of the premium payments (i.e., the reduction or waiver of the co-payments or deductible for the federal employee is borne by the FEHBP Carriers).

Sidney L. Meyer
Executive Vice President

February 19, 1998
Via Fax: 202-418-0630

United Stated Office of Personnel Management
Office of the Inspector General
1900 E Street, N.W., Room 6400
Washington, DC 20415
Attention: Sanders P. Gerson
Deputy Assistant Inspector General for Audits

Re: **Silent PPO Review**

Dear Mr. Gerson:

I am writing on behalf of MultiPlan, Inc., in response to the draft, preliminary Report (the "Draft Report") that you prepared on completion of your review of the use of "silent" and "non-directed" preferred provider organizations ("PPOs") within the Federal Employees Health Benefits Program ("FEHBP"). We appreciate the OIG's hard work on this complex and sensitive issue and the opportunity to comment on the Draft Report.

As an initial matter, we concur with your view that giving health payers access to provider discounts through subterfuge or misrepresentation would constitute, at the very least, an unethical practice in the FEHBP. MultiPlan, Inc. strongly opposes these so-called "silent" PPOs. We also are pleased, but not surprised, that OIG's review has confirmed that MultiPlan is not a silent PPO and does not engage in such practices. Indeed, OIG's review, which was performed in accordance with generally accepted government auditing standards for performance audits, demonstrates that MultiPlan had written contracts in place in every case reviewed and that all but one of the MultiPlan claims reviewed were processed in accordance with MultiPlan's provider contracts. In the case of that one claim, MultiPlan inadvertently extended a discount to the FEHBP plan of $1.87 -- a trivial error. As this example illustrates, MultiPlan's claim payment accuracy far exceeds the FEHBP's own standard for accuracy of payment. *See* Office of Personnel Management, *Financial Statements Fiscal Year 1996* at 56-57.

America's Managed Care Partner

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New York NY 10003-1004
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Fax: (212) 780-0410
smeyer@multiplan.com

We therefore ask that you expressly state in the final Report that MultiPlan is not a "silent" PPO and does not engage in "silent" PPO practices, and that all of MultiPlan's claims reviewed were processed under written contract administered in a manner that exceeds FEHBP standards for accuracy of payment.

The OIG has conducted a careful and professional review of this matter The Draft Report, however, includes some language that is inconsistent with the OIG's data and conclusions as presented in the Draft Report. It also uses some terms in a manner that is misleading and inaccurate. We ask that you correct these points, which are described below, in your final Report.

First, on pages 6-7, the Draft Report states that "anecdotal evidence" may justify concern on the part of the Committee on Government Reform and Oversight that medical providers are perhaps being victimized. This "anecdotal evidence," however, is not disclosed. And, in any event, the OIG's factual investigation refutes this "evidence" and dispels any basis for concern. We urge that this passage be deleted, less it be quoted out of context in support of a conclusion directly contrary to that reached in the OIG's review. For the same reason, the discussion of claims payment should be deleted from section B, on pages 6-7. Rare instances of inaccurate payment under written contracts is a separate topic from "vitalization" of providers under "silent" PPOs, and is fully addressed in section C.

Second, the Draft Report inaccurately implies that surveyed vendor's contracts with network providers are "vague" and create expectations on the part of providers that are not being fulfilled. This unsupported conclusion is in stark contrast to the conclusion regarding contract compliance, which is supported by a detailed claims audit. The report does not cite a single instance in which the OIG concluded that a provider had reason to be confused regarding the terms of its contract with MultiPlan or one of the other vendors or in which a specific provider's reasonable contractual expectations were not met. For these reasons, the Draft Report's discussion regarding allegedly vague contract terms and unmet provider expectations should be deleted.

Third, the Draft Report's use of the terms "directed PPO" and "non-directed PPO" is inaccurate. MultiPlan is classified as "non-directed", but MultiPlan does provide varying degrees of direction in its work with FEHBA plans.

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Enclosure
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MultiPlan requires, for example, that its clients share with subscribers the savings realized from its provider discounts by calculating the subscriber's coinsurance payment on the basis of the discounted rate. This results in a direct reduction in out-of-pocket expenses or FEHBP subscribers who use MultiPlan network providers. If, as some suggest, financial incentives are essential to a directed PPO arrangement, then MultiPlan meets this definition.

But financial incentive are not the only effective way to steer subscribers to network providers. For example, MultiPlan maintains a web site referral service on the Internet that is so extensive and accessible that it won an award from USA Today. We encourage you to review the site, which is at http://www.multiplan.com. Similarly, MultiPlan operates a 24-hour-a-day toll-free referral line staffed by nurses, and the FEHBA plans have been notified of this referral line. MultiPlan also offers a transfer assistance program that arranges for patients that are in a non-network hospital to be safely transferred to a network hospital.

Finally, steerage is not the only reason providers agree to extend discounts to MultiPlan. or example, MultiPlan's arrangements result in much better cash flow for network providers. MultiPlan requires its clients to make timely payment to providers and offer pre-audit payments and prepayment programs as a deposit or guarantee for bed days or for specific procedures. These programs provide concrete, financial benefits to MultiPlan's network providers. MultiPlan also provides quality support for network providers through its rural health care support, credentialing and certification, discount purchasing programs for medical services and supplies, and an extensive library of critical pathways that are shared with all of our network providers. These programs directly benefit our network providers. Equally important, however, they encourage high quality of care for FEHBP subscribers.

For these reasons, we urge you to revise the Draft Report to note that benefit differentials are not the only appropriate form of steerage, and that PPOs such as MultiPlan *do* direct subscribers to providers in their networks. In addition, we ask that the final Report state that steerage is not the only benefit that FEHBP providers can gain from membership in a PPO network.

Fourth, the Draft Report does not scrutinize the practices of entities that operate PPOs that the Draft Report labels "directed." Many of these entities, for example, contract with hospitals for an EPO rate, and/or HMO rates and/or for a PPO rate. The OIG review did not examine whether the directed PPOs accessed the correct rate in accordance with the contract term. to provide a more balanced assessment of whether health care providers are being "victimized" by FEHBP payers -- the stated purpose of the Draft Report -- the OIG's review should be expanded to

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include the practices of so-called "directed" PPOs. If this is not practical at this time, the report should note a minimum that there is also the potential for abuse by the PPO's that the Draft Report labels "directed," and that the OIG has not reviewed their practices.

Fifth, the Draft Report should note that OPM's 1993 call letter encouraging FEHBP carries to obtain the lowest price available for all goods and services is entirely consistent with existing legal requirements. *See* 48 C.F.R. § § 1600 *et seq.* OPM obviously did not intend for the carriers to do this through unethical or illegal means.

In summary, Provider discount arrangement with PPO's exist today for a variety of reasons. These reasons include direction of patients, collection and cash flow advocacy and quality support. The depth of discount vary as does the reason for providing them. This is all part of the process that helps keep health care in America self regulated as to price and the world leader as to quality.

Again, we appreciate the opportunity to comment on the Draft Report.

Please call Harvey Sigelbaum or me if you have any questions, or if we can be helpful to you in any way.

Very truly yours,

Sidney L. Meyer
Executive Vice President
Chief Legal and Legislative Affairs Officer

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Enclosure
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VIII. CHANGES IN EXISTING LAW

In compliance with paragraph 12 of rule XXVI of the Standing Rules of the Senate, changes in existing law made by the bill, as reported are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

TITLE 5, UNITED STATES CODE

* * * * * * *

CHAPTER 59—ALLOWANCES

* * * * * * *

SUBCHAPTER IV—MISCELLANEOUS ALLOWANCES

* * * * * * *

§ 5948. Physicians comparability allowances

(a) Notwithstanding any other provision of law, and in order to recruit and retain highly qualified Government physicians, the head of an agency, subject to the provisions of this section, section 5307, and such regulations as the President or his designee may prescribe, may enter into a service agreement with a Government physician which provides for such physician to complete a specified period of service in such agency in return for an allowance for the duration of such agreement in an amount to be determined by the agency head and specified in the agreement, but not to exceed—

(1) * * *

(2) [$20,000] *$30,000* per annum if the Government physician has served as a Government physician for more than twenty-four months.

For the purpose of determining length of service as a Government physician, service as a physician under section 4104 or 4114 of title 38 or active service as a medical officer in the commissioned corps of the Public Health Service under Title II of the Public Health Service Act (42 U.S.C. ch. 6A) shall be deemed service as a Government physician.

* * * * * * *

CHAPTER 89—HEALTH INSURANCE

Sec.
8901. Definitions.

* * * * * * *

8903b. Authority to readmit an employee organization plan.

* * * * * * *

§ 8901. Definitions

For the purpose of this chapter—

(1) "employee" means—

(A) * * *

* * * * * * *

(7) "carrier" means a voluntary association, corporation, partnership, or other nongovernmental organization which is lawfully engaged in providing, paying for, or reimbursing the cost of, health services under group insurance policies or contracts, medical or hospital service agreements, membership or subscription contracts, or similar group arrangements, in consideration of premiums or other periodic charges payable to the carrier, including a health benefits plan duly sponsored or underwritten by an employee [organization;] *organization and an association of organizations or other entities described in this paragraph sponsoring a health benefits plan;*

* * * * * * *

§ 8902. Contracting authority

(a) * * *

(k)(1) When a contract under this chapter requires payment or reimbursement for services which may be performed by a clinical psychologist, optometrist, nurse midwife, nursing school administered clinic, or nurse practitioner/clinical specialist, licensed or certified as such under Federal or State law, as applicable, or by a qualified clinical social worker as defined in section 8901(11), an employee, annuitant, family member, former spouse, or person having continued coverage under section 8905a of this title covered by the contract shall be free to select, and shall have direct access to, such a clinical psychologist, qualified clinical social worker, optometrist, nurse midwife, nursing school administered clinic, or nurse practitioner/nurse clinical specialist without supervision or referral by another health practitioner and shall be entitled under the contract to have payment or reimbursement made to him or on his behalf for the services performed.

(2) Nothing in this subsection shall be considered to preclude a health benefits plan from providing direct access or direct payment or reimbursement to a provider in a health care practice or profession other than a practice or profession listed in paragraph (1), if such provider is licensed or certified as such under Federal or State law.

[(2)] *(3)* The provisions of this subsection shall not apply to comprehensive medical plans as described in section 8903(4) of this title.

* * * * * * *

[(m)(1) The provisions of any contract under this chapter which relate to the nature or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans to the extent that such law or regulation is inconsistent with such contractual provisions.]

(m)(1) The terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans.

* * * * * * *

§ 8902a. Debarment and other sanctions

(a)(1) For the purpose of this section—

(A) the term "provider of health care services or supplies" or "provider" means a physician, hospital, or other individual or entity which furnishes health care services or supplies;

(B) the term "individual covered under this chapter" or "covered individual" means an employee, annuitant, family member, or former spouse covered by a health benefits plan described by section 8903 or 8903a; **[**and**]**

(C) an individual or entity shall be considered to have been "convicted" of a criminal offense if—

(i) * * *

* * * * * * *

(iv) in the case of an individual, the individual has entered a first offender or other program pursuant to which a judgment of conviction for such offense has been withheld;

without regard to the pendency or outcome of any appeal (other than a judgment of acquittal based on innocence) or request for relief on behalf of the individual or entity**[**.**]***; and*

(D) the term "should know" means that a person, with respect to information, acts in deliberate ignorance of, or in reckless disregard of, the truth or falsity of the information, and no proof of specific intent to defraud is required;

(2)(A) Notwithstanding section 8902(j) or any other provision of this chapter, if, under **[**subsection (b) or (c)**]** *subsection (b), (c), or (d)*, a provider is barred from participating in the program under this chapter, no payment may be made by a carrier pursuant to any contract under this chapter (either to such provider or by reimbursement) for any service or supply furnished by such provider during the period of the debarment.

* * * * * * *

(b) **[**The Office of Personnel Management may bar**]** *The Office of Personnel Management shall bar* the following providers of health care services or supplies from participating in the program under this chapter:

(1) * * *

* * * * * * *

[(5) Any provider—

[(A) whose license to provide health care services or supplies has been revoked, suspended, restricted, or not renewed, by a State licensing authority for reasons relating to the provider's professional competence, professional performance, or financial integrity; or

[(B) that surrendered such a license while a formal disciplinary proceeding was pending before such an authority, if the proceeding concerned the provider's professional competence, professional performance, or financial integrity.**]**

(5) Any provider that is currently debarred, suspended, or otherwise excluded from any procurement or nonprocurement

activity (within the meaning of section 2455 of the Federal Acquisition Streamlining Act of 1994).

(c) The Office may bar the following providers of health care services from participating in the program under this chapter:

(1) Any provider—

(A) whose license to provide health care services or supplies has been revoked, suspended, restricted, or not renewed, by a State licensing authority for reasons relating to the provider's professional competence, professional performance, or financial integrity; or

(B) that surrendered such a license while a formal disciplinary proceeding was pending before such an authority, if the proceeding concerned the provider's professional competence, professional performance, or financial integrity.

(2) Any provider that is an entity directly or indirectly owned, or with a control interest of 5 percent or more held, by an individual who has been convicted of any offense described in subsection (b), against whom a civil monetary penalty has been assessed under subsection (d), or who has been debarred from participation under this chapter.

(3) Any individual who directly or indirectly owns or has a control interest in a sanctioned entity and who knows or should know of the action constituting the basis for the entity's conviction of any offense described in subsection (b), assessment with a civil monetary penalty under subsection (d), or debarment from participation under this chapter.

(4) Any provider that the Office determines, in connection with claims presented under this chapter, has charged for health care services or supplies in an amount substantially in excess of such provider's customary charge for such services or supplies (unless the Office finds there is good cause for such charge), or charged for health care services or supplies which are substantially in excess of the needs of the covered individual or which are of a quality that fails to meet professionally recognized standards for such services or supplies.

(5) Any provider that the Office determines has committed acts described in subsection (d).

Any determination under paragraph (4) relating to whether a charge for health care services or supplies is substantially in excess of the needs of the covered individual shall be made by trained reviewers based on written medical protocols developed by physicians. In the event such a determination cannot be made based on such protocols, a physician in an appropriate specialty shall be consulted.

[(c)] *(d)* Whenever the Office determines—

[(1) in connection with a claim presented under this chapter, that a provider of health care services or supplies—

[(A) has charged for health care services or supplies that the provider knows or should have known were not provided as claimed; or

[(B) has charged for health care services or supplies in an amount substantially in excess of such provider's customary charges for such services or supplies, or charged for health care services or supplies which are substantially in excess of the needs of the covered individual or which

are of a quality that fails to meet professionally recognized standards for such services or supplies;]

(1) in connection with claims presented under this chapter, that a provider has charged for a health care service or supply which the provider knows or should have known involves—

(A) an item or service not provided as claimed,

(B) charges in violation of applicable charge limitations under section 8904(b), or

(C) an item or service furnished during a period in which the provider was debarred from participation under this chapter pursuant to a determination by the Office under this section, other than as permitted under subsection (g)(2)(B);

* * * * * * *

[(d)] *(e)* The Office—

(1) * * *

* * * * * * *

[(e)] *(f)* In making a determination relating to the appropriateness of imposing or the period of any debarment under this section *(where such debarment is not mandatory)*, or the appropriateness of imposing or the amount of any civil penalty or assessment under this section, the Office shall take into account—

(1) * * *

* * * * * * *

[(f)(1) The debarment of a provider under subsection (b) or (c) shall be effective at such time and upon such reasonable notice to such provider, and to carriers and covered individuals, as may be specified in regulations prescribed by the Office.]

(g)(1)(A) Except as provided in subparagraph (B), debarment of a provider under subsection (b) or (c) shall be effective at such time and upon such reasonable notice to such provider, and to carriers and covered individuals, as shall be specified in regulations prescribed by the Office. Any such provider that is debarred from participation may request a hearing in accordance with subsection (h)(1).

(B) Unless the Office determines that the health or safety of individuals receiving health care services warrants an earlier effective date, the Office shall not make a determination adverse to a provider under subsection (c)(5) or (d) until such provider has been given reasonable notice and an opportunity for the determination to be made after a hearing as provided in accordance with subsection (h)(1).

* * * * * * *

(3) Any notice *of debarment* referred to in paragraph (1) shall specify the date as of which debarment becomes effective and the minimum period of time for which such debarment is to remain effective. *In the case of a debarment under paragraph (1), (2), (3), or (4) of subsection (b), the minimum period of debarment shall not be less than 3 years, except as provided in paragraph (4)(B)(ii).*

(4)(A) A provider barred from participating in the program under this chapter may, after the expiration of the minimum period of debarment referred to in paragraph (3), apply to the Office, in such

manner as the Office may by regulation prescribe, for termination of the debarment.

(B) The Office may—

(i) terminate the debarment of a provider, pursuant to an application filed by such provider after the end of the minimum debarment period, if the Office determines, based on the conduct of the applicant, that—

(I) there is no basis under [subsection (b) or (c)] *subsection (b), (c), or (d)* for continuing the debarment; and

* * * * * * *

[(6) The Office shall, upon written request and payment of a reasonable charge to defray the cost of complying with such request, furnish a current list of any providers barred from participating in the program under this chapter, including the minimum period of time remaining under the terms of each provider's debarment.]

[(g)(1) The Office may not make a determination under subsection (b) or (c) adverse to a provider of health care services or supplies until such provider has been given written notice and an opportunity for a hearing on the record. A provider is entitled to be represented by counsel, to present witnesses, and to cross-examine witnesses against the provider in any such hearing.

[(2) Notwithstanding section 8912, any person adversely affected by a final decision under paragraph (1) may obtain review of such decision in the United States Court of Appeals for the Federal Circuit. A written petition requesting that the decision be modified or set aside must be filed within 60 days after the date on which such person is notified of such decision.]

(h)(1) Any provider of health care services or supplies that is the subject of an adverse determination by the Office under this section shall be entitled to reasonable notice and an opportunity to request a hearing of record, and to judicial review as provided in this subsection after the Office renders a final decision. The Office shall grant a request for a hearing upon a showing that due process rights have not previously been afforded with respect to any finding of fact which is relied upon as a cause for an adverse determination under this section. Such hearing shall be conducted without regard to subchapter II of chapter 5 and chapter 7 of this title by a hearing officer who shall be designated by the Director of the Office and who shall not otherwise have been involved in the adverse determination being appealed. A request for a hearing under this subsection shall be filed within such period and in accordance with such procedures as the Office shall prescribe by regulation.

(2) Any provider adversely affected by a final decision under paragraph (1) made after a hearing to which such provider was a party may seek review of such decision in the United States District Court for the District of Columbia or for the district in which the plaintiff resides or has his or her principal place of business by filing a notice of appeal in such court within 60 days after the date the decision is issued, and by simultaneously sending copies of such notice by certified mail to the Director of the Office and to the Attorney General. In answer to the appeal, the Director of the Office shall promptly file in such court a certified copy of the transcript of the record, if the Office conducted a hearing, and other evidence upon which the findings and decision complained of are based. The court

shall have power to enter, upon the pleadings and evidence of record, a judgment affirming, modifying, or setting aside, in whole or in part, the decision of the Office, with or without remanding the case for a rehearing. The district court shall not set aside or remand the decision of the Office unless there is not substantial evidence on the record, taken as whole, to support the findings by the Office of a cause for action under this section or unless action taken by the Office constitutes an abuse of discretion.

(3) Matters that were raised or that could have been raised in a hearing under paragraph (1) or an appeal under paragraph (2) may not be raised as a defense to a civil action by the United States to collect a penalty or assessment imposed under this section.

[(h)**]** *(i)* A civil action to recover civil monetary penalties or assessments under subsection **[**(c)**]** *(d)* shall be brought by the Attorney General in the name of the United States, and may be brought in the United States district court for the district where the claim involved was presented or where the person subject to the penalty resides. Amounts recovered under this section shall be paid to the Office for deposit into the Employees Health Benefits Fund. *The amount of a penalty or assessment as finally determined by the Office, or other amount the Office may agree to in compromise, may be deducted from any sum then or later owing by the United States to the party against whom the penalty or assessment has been levied.*

[(i)**]** *(j)* The Office shall prescribe regulations under which, with respect to services or supplies furnished by a debarred provider to a covered individual during the period of such provider's debarment, payment or reimbursement under this chapter may be made, notwithstanding the fact of such debarment, if such individual did not know or could not reasonably be expected to have known of the debarment. In any such instance, the carrier involved shall take appropriate measures to ensure that the individual is informed of the debarment and the minimum period of time remaining under the terms of the debarment.

§ 8903. Health benefits plans

The Office of Personnel Management may contract for or approve the following health benefits plans:

(1) SERVICE BENEFIT PLAN.—One Government-wide plan, *which may be underwritten by participating affiliates licensed in any number of States,* offering two levels of benefits, under which payment is made by a carrier under contracts with physicians, hospitals, or other providers of health services for benefits of the types described by section 8904(1) of this title given to employees, annuitants, members of their families, former spouses, or persons having continued coverage under section 8905a of this title, or, under certain conditions, payment is made by a carrier to the employee, annuitant, family member, former spouse, or person having continued coverage under section 8905a of this title.

* * * * * * *

§ 8903b. Authority to readmit an employee organization plan

(a) In the event that a plan described by section 8903(3) or 8903a is discontinued under this chapter (other than in the circumstance described in section 8909(d)), that discontinuation shall be disregarded, for purposes of any determination as to that plan's eligibility to be considered an approved plan under this chapter, but only for purposes of any contract year later than the third contract year beginning after such plan is so discontinued.

(b) A contract for a plan approved under this section shall require the carrier—

(1) to demonstrate experience in service delivery within a managed care system (including provider networks) throughout the United States; and

(2) if the carrier involved would not otherwise be subject to the requirement set forth in section 8903a(c)(1), to satisfy such requirement.

§ 8909. Employees Health Benefits Fund

(a) * * *

* * * * * * *

(e)*(1)* Except as provided by subsection (d) of this section, when a plan described by section 8903(3) or (4) or 8903a of this title is discontinued under this chapter, the contingency reserve of that plan shall be credited to the contingency reserves of the plans continuing under this chapter for the contract term following that in which termination occurs, each reserve to be credited in proportion to the amount of the subscription charges paid and accrued to the plan for the year of termination.

(2) Any crediting required under paragraph (1) pursuant to the discontinuation of any plan under this chapter shall be completed by the end of the second contract year beginning after such plan is so discontinued.

(3) The Office shall prescribe regulations in accordance with which this subsection shall be applied in the case of any plan which is discontinued before being credited with the full amount to which it would otherwise be entitled based on the discontinuation of any other plan.

* * * * * * *

○